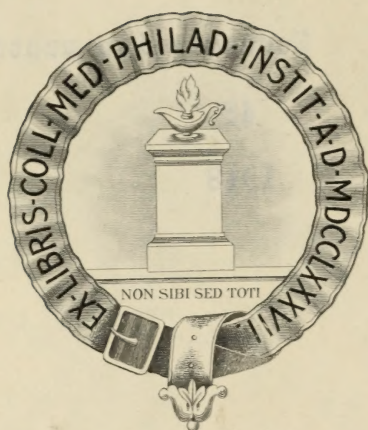




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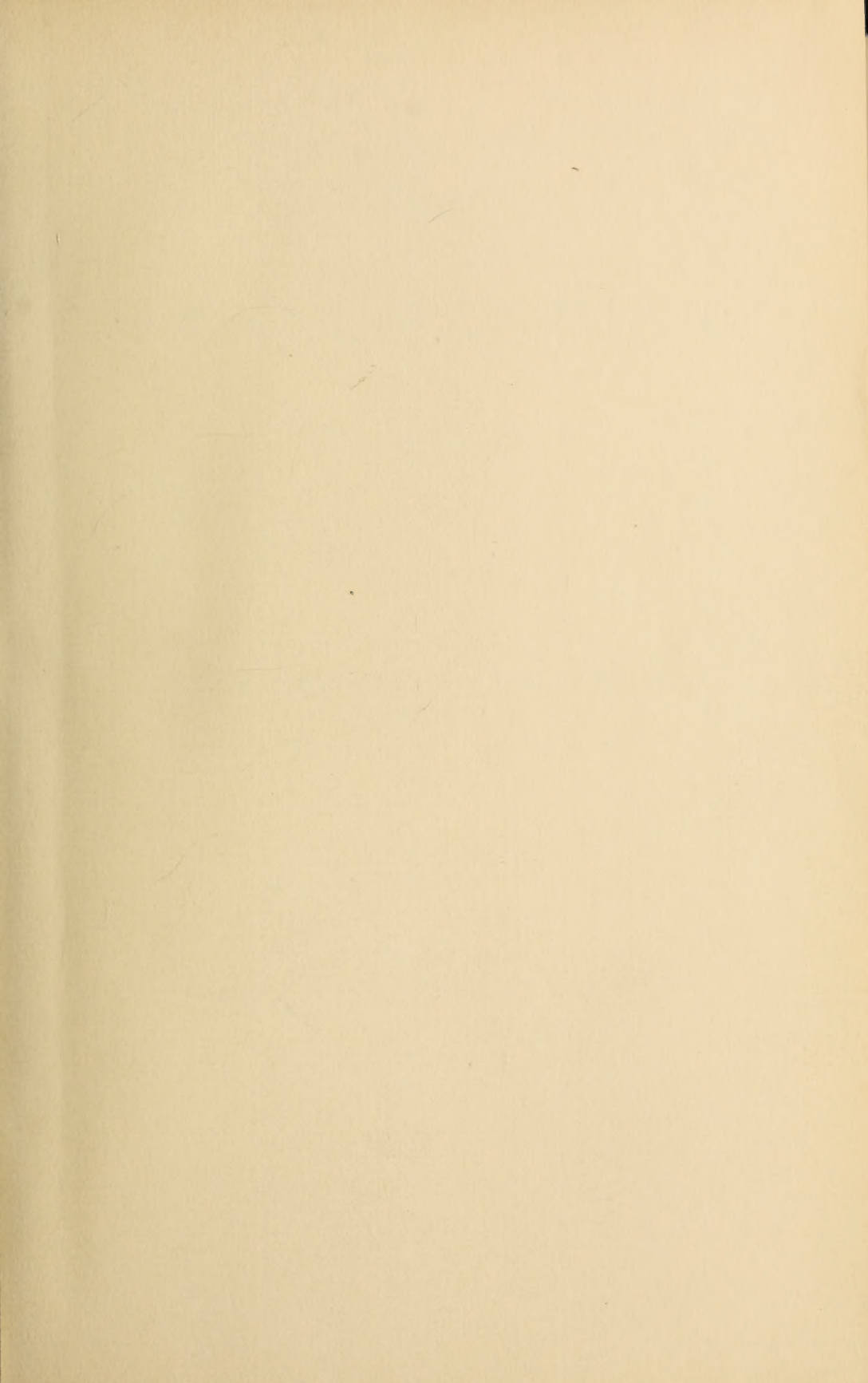

















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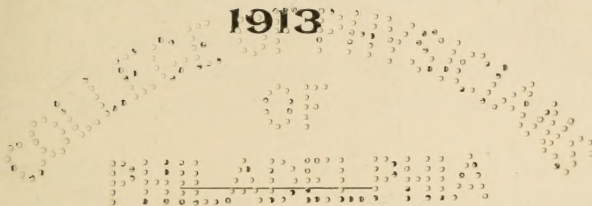
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# The HAHNEMANNIAN Monthly

VOLUME FORTY-EIGHTH.

JANUARY TO DECEMBER,  
1913



EDITED BY

G. HARLAN WELLS, M. D.  
State Society Editor, GILBERT J. PALEN, M. D

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PHILADELPHIA,  
1913

A large, stylized graphic of a globe made of dots, with the words "GLOBE" and "EARTH" written in a similar dot-matrix font across it. The globe is composed of a grid of dots, with some dots missing to create a grid pattern. The words "GLOBE" and "EARTH" are written in a similar dot-matrix font across the globe. The background is a light beige color.



# THE HAHNEMANNIAN MONTHLY.

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JANUARY, 1913

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A THEORY OF *SIMILIA SIMILIBUS CURANTUR* SUBMITTED TO THINKING  
AND SCIENTIFIC HOMŒOPATHISTS.

BY

JOSEPH C. GUERNSEY, A. M., M. D., PHILADELPHIA.

THE question, "What law or laws cause and control the precept *Similia Similibus Curantur*?" has long occupied the minds of thinking people. Some time ago I became impressed with the following possible explanation and submitted it to the consideration of some of my confreres; their replies are appended.

I am authorized to say that the HAHNEMANNIAN MONTHLY will be glad to receive for publication brief essays stating why and how, in their authors' opinion, *Similia Similibus Curantur* is nature's law of cure. All such contributions should be sent to the editor and it is hoped that a general SYMPOSIUM conducted and supported by the profession will shed bright light on this exceedingly fertile topic.

We have all read and have heard numerous theories and explanations as to *why* our law of cure, *Similia Similibus Curantur*, is a law of nature and *how* it operates as such. Here is an illustration I have never before seen used. In that racy old English book "Tristram Shandy," chapter XIX, we find this statement:

"So that, like equal forces acting against each other in contrary directions, he thought they mutually destroyed each other's effects."

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This line of reasoning can perhaps be fitted to our therapeutic law *Similia Similibus Curantur* as follows: A natural disease or case of sickness (in Mr. A.) presenting a certain set of symptoms is cured by the administration of a drug which creates an artificial disease in the human system with a set of symptoms similar to those existing in Mr. A.; each set of symptoms being an equal force "acting against each other" (in the human system) "in contrary directions . . . mutually destroys each other's effects." Hence, both diseases being destroyed, the natural and the artificial, health results.

The theory I suggest differs from that of Hahnemann who explains the "probable" *modus operandi* of the homœopathic method of cure in his *Organon*, Secs. 24-28, inclusive; Sec. 148, Sec. 155, etc. He there and elsewhere teaches that by exhibiting the "simillimum" to a set of symptoms (i. e., a natural disease) existing in the human system a stronger, "more intense," "artificial" disease is created which, by its dominance, conquers and annihilates the weaker (natural) disease, thus producing a cure.

Hahnemann says the "artificial" disease being stronger, "more intense," it overcomes the natural disease.

My suggestion is that perhaps both diseases (natural and artificial) are "equal forces" which "acting against each other in contrary directions . . . mutually destroy each other's effects."

In the foregoing I do not in the least seek to oppose or to controvert Hahnemann's law of *Similia Similibus Curantur*. On the contrary, I want, if possible, to strengthen and confirm it.

I do not know where Hahnemann got his idea that the artificial disease was stronger than the natural disease—I do not think he tells us. He seems merely to assume and decide that the artificial disease is stronger than the original (or natural) disease and therefore destroys it *vi et armis*!

PITTSBURGH, May 1, 1912.

MY DEAR GUERNSEY:

I have read your brief essay with a great deal of interest, and believe you hit on a very reasonable explanation of how homœopathic cures are made, or at any rate, how medicine may act in advancing a cure.

You, of course, know that Hahnemann never used the word



"curantur," but always the subjunctive "curentur." As a matter of fact he set forth a therapeutic rule to be followed in the treatment of diseases, which can be rendered "Let likes be *treated* by likes." However, this old story is a very familiar one to you. Now, whether, as some people argue to-day, the effect of a curative medicine is simply to raise the opsonic index so that the inimical conditions or elements are eliminated; whether it is as Hahnemann describes, or whether it is as you have so well set forth is largely a matter of speculation, but we can say when a cure takes place with the man in the Scripture, "Whereas I was blind I now see." The great fact of a cure remains. These questions have a professional interest and I think you will do well to let your theory come to light. With kindest regards, believe me,

Yours sincerely,

JAMES H. McCLELLAND.

ERIE, PA., August 6, 1912.

DEAR DOCTOR GUERNSEY:

Your adaptation of the proposition that any present force may be neutralized by a similar force, is well suited to throw light on the mode of action of homœopathic remedies. Hahnemann established the *fact* beyond any argument, that the drug capable of causing any particular set of symptoms, was the best drug to select for the cure of similar symptoms in the sick.

His own *theory* or the *mode* of cure, as stated in his Organon, section 34, is that the medicine must produce "an artificial disease, similar to that which is to be cured; for it is this resemblance alone, joined to the greater intensity of the artificial disease, that gives to the latter the faculty of substituting itself in the place of the former and obliterating it." He then, to illustrate the action of nearly but not quite similar diseases, instances cases of measles suspended by smallpox, or scarlet fever suspended by vaccinia, and of vaccinia by scarlet fever. These "suspensions" were not cures, for the former disease in each case resumed and finished its course when the intruding disease was through. In section 44 he says, "Two diseases that resemble each other closely can neither repel, nor suspend each other, nor can they exist beside each other in the same organism, and form a double or complicated disease."

Now, measles and scarlet fever are apparently similar, so that before the time of Sydenham they were regarded as the

same disease;—that they are not so similar as to cure each other, let experience show.

The present writer has seen measles arrested and wholly replaced by scarlet fever, and in another case (both ending fatally) has seen measles and scarlet fever “existing beside each other” forming “a double or complicated disease.”

On the other hand, Hahnemann cites, as true homœopathic cures, cases of ophthalmia cured by smallpox, and chronic tetter cured by measles, while in recent times we have seen rheumatism cured by bees stinging, and even by a stroke of lightning! But, as Hahnemann truly argues, these things are too severe for practical use, hence drugs capable of causing similar diseases, instead of such as arrest or suppress function, must be used. And right here is Hahnemann’s fallacy, when he says the drug capable of causing similar disease, does, in curing, actually cause an “artificial disease,” “of greater intensity.”

Your own line of reasoning suggests the truth, that it is not necessary to actually produce with the homœopathic drug “an artificial disease of greater intensity” than the existing one in the patient, but only to restore equilibrium in the cells of the cortical or gray matter, where all control of the functions of life resides, and this is done simply by bringing to bear a gentle, nerve-like force, from the readily absorbed attenuated drug, *capable* of causing, but not actually causing, a similar disease. That a battle of such attenuated forces in the midst of the structure of the appropriate nerve cells is adequate to the desired result upon disease, we can infer from a simile employed by the late Herbert Spencer in his biological studies, to the effect that the great consequences in structural change wrought by apparently insignificant forces acting on the nerve cells, are truly comparable to the great explosions that may be caused in magazines of powder, lyddite or dynamite, by the most insignificant spark or breath of flame.

The forces are in the body, they wait only for the equilibrium to be restored, by the mildest means, *on similar lines*, that can be employed.

Hahnemann, in section 26 of the Organon, in a note, justly observes, that sound will not obscure light, nor will noise be drowned by sunshine, yet a brass band will render an orator inaudible, and the sun will cause the stars of heaven to fade



from view. In homely phrase, "set a thief to catch a thief"—and why? because they know each other's haunts and paths. So the proven drug knows the paths to the same nerve-cells as are the seat of control of the disease of similar symptoms, but, once in the cell, the drug arrays its similar force against the force of the disease, and completely neutralizes it in its very stronghold. Thus we see that while the rule of selection is "Similia" the "*modus operandi*" of the cure itself is "Contraria."

EDWARD CRANCH.

NEW YORK, April 30, 1912.

DEAR DR. GUERNSEY:

In spite of the fact that I have always had a prejudice against the perfectly human desire to explain the Law of Similars, I have nevertheless had some theories of my own regarding the underlying reasons. It has always seemed to me that all the published reasons for the action of the Law are more or less far-fetched. One cannot explain why the Law of Gravitation acts; neither can he explain the Law of Electromagnetic induction. Keppler's Law and all the rest of the so-called laws in the natural world are more or less arbitrary statements intended to formulate certain sequences or relations. Of course, the scientific mind is hardly satisfied to accept the dogmatic statement and it naturally seeks to find the underlying cause of things. I observe that some scientist has recently offered a new explanation of the Law of Gravitation. Any explanation satisfactory to the mind of man to-day will probably be set aside by the next generation. Is it not quite true in homœopathy, that any attempt to explain the wherefore of the Law of Similars or the theory of Similars is likely to be set aside?

It seems to me that the trouble with your theory is that it is very doubtful if both diseases (natural and artificial) are equal forces acting against each other in contrary directions. As a matter of fact, what we call disease is acting in a certain direction and to cure it we give a remedy capable of producing a disease acting in the same direction. It does not act in a contrary direction; it acts in the same direction. Therefore, it is not true that both diseases are acting against each other in contrary directions, as your hypothesis states.

Having criticised your theory and at the same time expressed my own lack of appreciation of any effort to explain a

natural law, yet I cannot resist the temptation to suggest some views of my own.

Beyond the few objective things that are met in what we call disease, the most conspicuous manifestations of so-called disease lie in the subjective symptoms. I am wondering if the symptoms of disease, so-called, are not after all simply the evidence of Nature's effort to rid herself of disease. Who knows but the night sweats of phthisis is Nature's way of eliminating the toxins? Is it not perhaps unscientific to stop these sweats and thus retain in the system poisonous material which may act simply as fuel to increase the conflagration and more quickly burn out the life? In disease, Nature manifests her efforts to relieve herself by certain symptoms. In a sense, she is moving the fly-wheel of the engine, making laborious efforts to put it in motion. The physician does not now enter into the case with the intention of giving a remedy which will act in the opposite direction of the movement of this wheel, as suggested in your theory, but he gives gentle aid by helping to operate the wheel in the same direction. In this way he gives practical application to the law of similars and by his prescribing helps Nature on her way.

It is hardly worth while to continue the argument. You are doubtless right in your theory, but you have asked for a frank expression of opinion and I have told you what I think about it. We will be good friends even though we do not agree regarding the secrets in the jewel box of old Mother Nature.

With kindest personal regards,

Cordially,

ROYAL S. COPELAND.

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CARCINOMA OF THE FEMALE GENITALIA.—Theilaber has restated his belief that malignant diseases have a traumatic origin in addition to defective nutrition locally because of obliteration and stenosis of vessels. In regard to treatment he believes that when the body of the uterus is affected vaginal hysterectomy is the best procedure. The results have been good, and extension of the parametrium is not often seen, except in the disease. When the disease starts in the cervical mucous membrane removal of the uterus together with the parametrium is called for. He calls attention to the fact also that excision of the cervix is also justifiable. If the parametria are involved no operation will be ultimately successful. When the vaginal portion is affected without demonstrable involvement of the parametrium the best operation has not yet been determined, since opinions differ. The author suggests that we should not forget the good results obtained by the actual cautery.—*Arch. f. Gyn.*, Vol. 96, 561.



## DISEASE; ITS CAUSATION AND CURE.

BY

DONALD MACFARLAN, B. S., M. D., PHILADELPHIA.

No thinking man nowadays will gainsay the perfectly evident fact that we are all, without exception, the complex of our ancestors. This holds true in a physical as well as a dynamic and psychologic sense. The stamina or frailty of the physical framework is at once and daily recognized in the mirrored replica of the offspring—strength begetteth strength—weakness begetteth weakness. The ability to resist disease—that inherent *dynamis* which hovers so guardedly about some and seems so airily prone to shun others is everywhere seen and noted by us all.

This unseen *dynamis*, which presides over us and aids us in such manner that our various organs may dependently functionate in proper fashion when we are in health, is of vital importance when we come to disease. In disease, we have, of course, a dynamic aberration except the malady in question be a purely surgical lesion. These dynamic aberrations which assuredly constitute nearly all diseased states ought certainly to claim our closest attention if we are to deal with disease scientifically.

It is from the totality of symptoms which in reality serves as a mirror of the improperly functioning bodily structures that we have a clue to guide us in the best remedy indicated. Who ever suffered from a disease, non-surgical in character, of one organ and that alone? Take concrete examples—a patient is referred to us with a presumptive diagnosis of chronic gastritis. If we sedulously look into the case we may see an unstable nervous system undoubtedly induced by strong drink. We may see periods of marked costiveness and copremia attended with headache, general malaise and disturbed rest at night. We may see certainly outbursts of temper incident to certain domestic troubles of inconsequential character. Yet some of us will say this is a case of chronic gastritis. Rather I would say a perverted craze for intoxicants which has drawn our patient into an illy functioning physical and mental state.

In considering healthy and diseased states I have never been able to consider the same intelligently without realizing

the essential character of matter as held together by some force which of itself is non-physical in character. These atoms held together and associated by some wonderful force, in the aggregate constitute an organ whose function in the main is of a specific nature. The same law, of course, holds in respect to substances not constituting human bodily framework which may be introduced orally into the human being.

Why is it that the successive increment of a hydroxyc radical gradually lessens the toxicity of the monatomic group of alcohols till we come to an alcohol—propenyl alcohol which is in reality a food. We know that each atom of itself must of necessity be invested with a very definite power of combining which necessarily in the act of combining creates in reality a new force matter, different from anything else in our world and having a most definite use as a therapeutic agent if used properly.

“Oh, mickle is the powerful grace that lies  
In plants, stones, herbs and their true qualities  
For naught so vile that on the earth doth live  
But to the earth some special good doth give.  
Nor aught so good but strained from that fair use  
Revolts at true birth stumbling on abuse.”

The exaltation of the curative property of each such substance is gradually evolved by the method first given to the medical world by Samuel Hahnemann, to-wit, dilution and succussion, dilution and succussion. The menstruum serving as a diluent, be it water or alcohol, or, in a less potent way, saccharum lactis (the latter in a glazed mortar and by trituration) is never changed wherefore the force of curative power is gradually awakened into life from the medical agent acted upon.

For practical purposes in the preparation of dynamized medicine the decimal scale as devised by Dr. Constantine Hering seems very appropriate, although the centesimal scale of Hahnemann's is equally efficacious although more difficult to carry out. By the systematic provings on the healthy the medicinal symptom-complex is effectually brought about and by working on the universal law of similars or correspondences, a cure can be effected and in a manner truly safe, rapid



and permanent. The cure will be brought about pleasantly as well.

The recent admirable work done by Sir Almroth Wright, of London, and his co-worker, Capt. S. R. Douglas on typhoidal vaccination as a protective agent against the acquisition of typhoid fever is certainly distinctively Hahnemannian in principle very largely. Sir Almroth Wright potentially induces a dynamization in a way by his act of attenuation—the killing of the living organism by heat. By this method he abrogates the lethal influence of the organisms and at the same time brings about a protective agent. The cure attained by Hahnemann's method is attained by dynamization and the law of similars is held to. It may very appropriately be designated dilutive dynamic similia induced by dilution and succussion. The cure by Sir Almroth Wright is attained by attenuation (cognate in Hahnemann's method being dilution and succussion, dilution and succussion), together with the principle of identities curing identities (a near cognate to the law of similia). Louis Pasteur, the celebrated Frenchman, really is the founder of Wright's method, as he devised by his inoculative passage experiments in animals the attenuation of bacterial influence in non-susceptible animals by passage and the exaltation of virulence by act of passage through susceptible ones.

Practically the same thing is distinctively true with diphtheria antitoxin and the discoverer of the same, von Behring, has also honorably stated the relationship of his discovery to the Hahnemannian principle. The brilliant cures, running very well up in the nineties as regards percentage cures in cases of hydrophobia, when taken early by the Pasteur treatment are also effected in a manner largely Hahnemannian in principle. The dried spinal cord of rabbits is here used as the curative agent. The dessicative process has its homologue in dilution and succussion, dilution and succussion.

Again, and in an admirably well written article in a recent issue of the *Medical Record*, a New York physician has recorded brilliant cures resulting, in cases of specific urethritis by the patient himself, under direction, actually taking *per orem* his own contaminated urine loaded with the offending organisms.

The principles of the law of similars is, however, a law long known before the Hahnemannian era. Before the appearance of the first dissertation on homœopathy in *Hufeland's Journal*

in 1796 the celebrated Swedish scientist and theologian, Emanuel Swedenborg, announced to the world his marvelous doctrine of correspondence between things natural and spiritual. In fact he well shows, as he asserts, that the science of correspondences is the science of sciences.

In the field of pure mathematics the logarithmic computations as devised by Sir John Napier, of Murchiston, as far back as the early part of the seventeenth century are nothing more or less, as regards the characteristic and mantissa, than the very same law. When we consider it, even in the advice given us on ordinary mundane affairs by the immortal bard Shakespeare himself, as regards even such a common thing as the management of a rebellious shrew, we certainly see the principle of the simillimum ably elucidated.

In very truth, do we not see before our very eyes in matter-of-fact affairs of common experience the same old law cropping up, again and again in variously different guises—such catch phrases as “set a thief to catch a thief,” and “diamond cut diamond” might well be cited as common examples.

If we go back to Biblical times, during the Mosaic period, we see the very same old principle in use—in this case the setting up of a brazen serpent to heal those bitten by the same.

So in one way or another and in all ages of time the truth is expounded in many different things, but always on the same underlying principle. When with the knowledge of these universal laws we experience the truth as sublimed through the school of experience then will we become in very fact potent agents in the uplift of mankind, provided we guide ourselves on charitable and sane courses.

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EFFECT OF SALVARSAN ON LUETIC OCULAR AFFECTIONS.—E. Seidel treated 12 cases (9 acute, 3 quiescent) of interstitial keratitis with intravenous and subcutaneous injections of salvarsan. In only two of the acute cases was no satisfactory result obtained. In one of them the other eye, too, became affected; in both, however, the disease ran a mild course. No result was obtained or expected in the three quiescent cases where salvarsan was used as a prophylactic. Six cases of iritis (2 acute, 2 relapsing, 1 chronic with plus tension, 1 nonluetie, but with a luetic history) were subjected to the treatment. In only the acute cases was a favorable result obtained.

In two cases of palsy of the ocular muscles no cure was expected. In a case of bilateral choked dish of doubtful etiology and one of old choroiditis the only improvement noted was in the general condition.—*Graef's Archiv. f. Ophthalm.*

**NEPHRITIS---ANALYTICAL DIAGNOSIS.**

BY

WALTER W. SEIBERT, M. D., EASTON, PA.

(Read before the Lehigh Valley Homœopathic Medical Society at Bethlehem, Pa.,  
September 5, 1912.)

THE diagnosis of nephritis usually is comparatively easy, being determined by the presence of albumin in the urine. The differentiation of the various forms of nephritis is but little more difficult. But when we have an obscure case, our resources are apt to be heavily drawn upon and only by the most careful examination can we hope to come to an accurate conclusion. These are the cases requiring a careful analysis of the symptoms of the patient and a painstaking examination of the urine. To this class can best be applied the analytical methods which form the subject of this paper.

In a general way the affections to which the kidneys are subject may be divided into three classes: Actual diseases of the kidney and pelvis of the kidney; tumors of the kidney and about the kidney; other diseases which may influence the character of the secretions of the kidney. The first group may be subdivided into: first, catarrhal or interstitial affections; second, croupous or parenchymatous affections; third, suppurative affections.

The catarrhal subdivision includes:

- Irritation of the kidney.
- Acute catarrhal nephritis.
- Chronic catarrhal nephritis.
- Cirrhosis of the kidney.
- Catarrhal pyelitis.
- Tuberculosis of the kidney.

The croupous subdivision includes:

- Acute croupous nephritis.
- Subacute croupous nephritis.
- Chronic croupous nephritis.
- Fatty degeneration of the kidney.
- Waxy degeneration of the kidney.
- Atrophy of the kidney.
- Chronic croupous nephritis with an acute croupous recurrence.



The suppurative subdivision includes:

Acute suppurative nephritis.

Chronic suppurative nephritis.

Acute suppurative pyelitis.

Chronic suppurative pyelitis.

This classification is not an arbitrary one, but the natural result obtained in an analysis of the symptoms as they appear in these various diseases and as will be demonstrated in the analytical key which concludes this paper.

Taking up the diseases in the order given, we will briefly observe the urinary symptoms of each.

*Irritation of the Kidney.*

In this condition we always find a few blood and pus cells and a few epithelia from the convoluted tubules. When the red blood cells are numerous, the epithelia may also be increased in number and connective tissue shreds may be found. This condition is due to hemorrhage. When mucus is in increased quantity as threads or corpuscles, we suspect beginning acute eruptive and inflammatory diseases. Casts are never found in this state of the kidneys, because they indicate an inflammation and our case would at once fall into one of the following diseases.

*Catarrhal, Interstitial or Desquamative Nephritis.*

*Acute.* Here we have albumin absent or scant; quantity of urine normal or decreased; specific gravity normal or increased; color normal or darker than normal. The diagnostic features of this ailment are blood corpuscles, pus cells, and epithelia from the convoluted and narrow tubules, all in moderate or large numbers. When epithelia from the straight collecting tubules appear, our case has become more severe. The same may be said of the appearance of cells from the pelvis of the kidney, ureters and bladder. Casts are usually absent. When found, they are hyaline and from the narrow tubules.

*Chronic.* When this disease assumes a chronic form the quantity of urine becomes increased, the specific gravity decreased, and the color becomes pale. Albumin is scant or absent, red blood corpuscles few or absent and pus corpuscles moderate in number. A great number of red blood corpuscles indicates an acute attack engrafted on a chronic or in one kidney an acute attack and in the other a chronic. Fat globules and granules are always found free and in the cells in this and all other chronic diseases of the kidney and are never found in

acute diseases. Epithelia from the straight collecting tubules indicate severity and may be accompanied by cells from the pelvis, ureter and bladder. When there has been a hemorrhage, crystals of hæmatoidin—rust brown in color—may be seen. Casts are absent or few in number.

*Cirrhosis of the Kidney.*

This is really the final stage of catarrhal nephritis. The quantity, color and specific gravity of the urine and the amount of albumin present are as in chronic catarrhal nephritis. An absence of salts, other symptoms as in the preceding, would be diagnostic; but occasionally we may have an abundance of salts and then, if other symptoms point to cirrhosis, we may feel sure only one kidney is affected. Of course, in the latter event our prognosis would be better. The diagnostic features would be a few small connective tissue shreds, a small number of pus corpuscles and a small number of epithelia from the convoluted and straight tubules; all cells and corpuscles containing fat and accompanied by free globules and granules of fat. Epithelia may also appear from the pelves, ureters and bladder. The pus corpuscles show a broken down constitution by being finely granular and having a faint or broken outline.

*Catarrhal Pyelitis.*

This may occur in connection with a catarrhal nephritis and then we have the symptoms of the nephritis plus an abundance of cells from the pelvis. When it is uncomplicated, the symptoms are the same except that the kidney cells are absent or very few in number. As this disease is most often the result of calculus or due to irritation of too concentrated a urine, we find usually an abundance of salts.

*Tuberculosis of the Kidney.*

Here the urine is as in chronic catarrhal nephritis except that it is turbid. Whenever a turbidity in pale urine is present at micturition, tubercle bacilli—the presence of which would be diagnostic—should be sought. Sometimes they seem to be absent but perseverance will bring them to light. Sediment is often slight though when ulcers appear it will become profuse. Whenever there is ulceration of the bladder we should suspect tuberculosis of the kidney. Early in the disease the symptoms are those of chronic catarrhal nephritis; later, connective tissue shreds appear and there may be some resemblance to cirrhosis. But the presence of tubercle bacilli will absolutely determine the diagnosis. The pus corpuscles



are pale and finely granular, showing a broken down constitution.

In the catarrhal subdivision just described we found albumin scant or absent and the casts few or none. In the croupous and suppurative subdivisions to follow we will find the albumin and casts more or less abundant.

*Croupous or Parenchymatous Nephritis.*

*Acute.* The quantity and total solids of the urine are decreased and the color is dark. Albumin is more or less abundant. Pus and red blood corpuscles and epithelia from the convoluted tubules are present in moderate or large numbers. Epithelia from the straight collecting tubules, pelves, ureters and bladder may also be present. Connective tissue shreds are usually small; when they appear of large size, the prognosis becomes more grave. When uræmic convulsions have appeared we may find creatinine crystals and sometimes, after a severe hemorrhage, masses of febrin. Blood appears in casts only in the severer forms of the disease. Casts are always present and may be either hyaline or epithelial or only the latter. Mucus appears in cylindroids which must not be mistaken for hyaline casts.

*Subacute.* At this stage the cells in the casts begin to break down and we have epithelial-granular casts. The fat granules and globules appear and we have epithelial-granular-fatty casts. Finally, we also have free fat granules and globules.

*Chronic.* Early in this stage we have the urine still decreased but later the quantity becomes greater, the specific gravity less, and the color pale. The amount of albumin is about as in the earlier stages. The real diagnostic features are numerous fat globules and granules and granular-fatty or fatty casts.

*Fatty Degeneration or Large White Kidney.*

When the fatty casts are numerous we have this condition. Some of the casts may then be from the straight collecting tubules. We will find red blood corpuscles and rarely needles of margaric acid. Large connective tissue shreds are always present. Epithelia from the convoluted and straight collecting tubules and probably from the pelves, ureters and bladder are found.

*Waxy Degeneration or Amyloid Kidney.*

This may be considered an end product of both catarrhal and croupous nephritis. The casts are waxy and of all sizes and the epithelia themselves may become waxy. In the earlier

stages the casts may be granular-waxy or fatty-waxy. Otherwise the symptoms are those of chronic nephritis.

*Atrophy of the Kidney.*

This disease is always the result of croupous nephritis. The urine is increased and loaded with albumin. The specific gravity is *very* low and the salts absent. Pus corpuscles, finely granular and maybe multinuclear, are found in moderate numbers. A moderate number of epithelia from the convoluted and straight collecting tubules are present, and, like the pus cells, contain plenty of fat granules and globules. In many instances the cells have broken down and the fat is found free. Casts are always abundant and fatty or waxy. Medium or large size connective tissue shreds appear in moderate numbers. We also usually have epithelia from the pelves, ureters and middle layer of the bladder.

*Chronic Croupous Nephritis with Acute Croupous Recurrence.*

Occasionally we may have this condition which with its absence of salts may be confused with the preceding. The differential features are numerous red blood corpuscles, few small connective tissue shreds and casts of all kinds and sizes. The pus corpuscles are quite abundant and show a poor constitution. Epithelia appear from the convoluted and straight collecting tubules in great numbers, many of which are studded with fat globules. There may be pyelitis, ureteritis and cystitis. Mucus is seen as threads and cylindroids.

As we have seen, the catarrhal diseases are distinguished by the scant or absent albumin and few or no casts and the croupous diseases by the more or less abundance of albumin and casts, so we find the suppurative subdivision characterized by urine of decreased quantity and specific gravity with large quantities of ropy pus and a moderate or large number of connective tissue shreds.

*Suppurative Nephritis.*

*Acute.* Urine is decreased in quantity, always cloudy and has a heavy sediment. The specific gravity is usually decreased. There is a large amount of albumin and an enormous quantity of pus. Red blood corpuscles are numerous and connective tissue shreds are seen in moderate or large numbers. There are epithelia from the convoluted and straight collecting tubules and sometimes from the pelvis. Casts, when present, mean a croupous complication.



*Chronic.* As in the acute form, pus is extremely abundant and epithelia from the convoluted and straight collecting tubules are present; the former being especially abundant in chronic suppurative nephritis. But here we have fat globules and granules—free and in the cells—and connective tissue shreds of large size and in great numbers and only a small number of red blood cells. Frequently rust-brown crystals of hæmatoidin are seen—free and in the cells—indicative of an old hemorrhage. Epithelia from the pelvis, ureters and bladder along with numerous bacteria are usually present. Endogenous new formations of pus corpuscles are found in the pelvic epithelia. When these are found in large numbers, pressure is indicated. Because of the presence of these and the fact that pus corpuscles migrate freely through the tissues, we can diagnose a perirenal abscess which has not opened into the kidney.

*Suppurative Pyelitis.*

*Acute.* The symptoms are precisely those of suppurative nephritis, except that the pelvic cells are more numerous than the kidney cells and the endogenous new formations may appear in the cells from the ureters. Epithelia from the convoluted tubules may not be found until late in the disease and then may also contain endogenous new formations. Epithelia from the bladder usually appear early and a cystitis develops.

*Chronic.* Again the symptoms are those of suppurative nephritis except that the pelvic cells predominate. That infallible sign of chronicity—fat globules and granules, free and in cells—connective tissue shreds large and numerous, and only a small number of red blood corpuscles differentiate the chronic and acute forms.

This concludes the diseases of the kidney itself and though we have taken nothing but the urinary symptoms as revealed by a urinary analysis, still I believe that upon these symptoms alone we can base a most accurate diagnosis provided we have made our examination with care. To arrive at a conclusion from the above symptoms offers many chances for error. With this in mind, I have devised the following analytical key which should automatically lead one to the accurate conclusion.

Just a few words in explanation before I close. This “key” may not be complete, but it is accurate so far as it goes and any additions desired can easily be made. All of the symptoms given above are not included—only the diagnostic ones. As

additions are made it may be necessary to include more symptoms. It is possible to arrive at two conclusions; when this occurs we have both diseases—the one as a complication of the other. Finally, we must not try to reach a definite diagnosis in an obscure case unless the full twenty-four hours' urine has been examined and that a number of times.

#### ANALYTICAL KEY.

#### DISEASES OF THE KIDNEYS—DIAGNOSIS.

##### *Catarrhal Nephritis.*

Albumin scant or absent; casts few or none.

Urine normal or decreased in quantity; specific gravity normal or increased; color normal or darker than normal.

Blood, pus and epithelia from the convoluted tubules few in number; *no* casts.

##### *Irritation of the Kidney.*

Blood and pus cells in moderate or large numbers; casts—hyaline—few or none.

Epithelia from the convoluted and narrow tubules in moderate or large numbers.

##### *Catarrhal Pyelitis.*

Epithelia from pelvis of kidney in moderate or large numbers.

##### *Chronic Catarrhal Nephritis.*

Urine increased in quantity; specific gravity decreased; color pale.

Pus cells in moderate or large numbers; connective tissue absent.

Epithelia from the kidney predominate.

##### *Cirrhosis of the Kidney.*

Pus cells few; connective tissue shreds few and small.

Urine pale and clear; absence of salts; usually epithelia only from the kidney.



*Tuberculosis of the Kidney.*

Urine pale and turbid; tubercle bacilli; usually cells from bladder as well as from kidneys.

Albumin and casts more or less abundant.

Urine normal or decreased in quantity; specific gravity normal or increased; color normal or darker than normal.

Casts—hyaline, epithelial and possibly blood; blood abundant; connective tissue shreds small and few; no fat globules or granules.

*Acute Croupous Nephritis.*

Casts—epithelial-granular, granular, epithelial-granular-fatty; blood cells moderate or few; connective tissue shreds more or less numerous and large; fat globules and granules.

*Subacute Croupous Nephritis.*

Urine increased in quantity; specific gravity decreased; color pale.

Blood cells few or absent; connective tissue shreds large and numerous.

Casts—granular, granular-fatty or fatty.

*Chronic Croupous Nephritis.*

Casts—fatty predominate.

*Fatty Degeneration of the Kidney.*

Casts—granular-waxy, waxy, fatty-waxy.

*Waxy Degeneration of the Kidney.*

Casts—numerous fatty and waxy; salts absent.

*Atrophy of the Kidney.*

Urine increased and loaded with albumin. Specific gravity very low. Salts absent. Casts abundant; fatty or waxy. Connective tissue shreds appear.

*Chronic Croupous Nephritis with an Acute Croupous Recurrence.*

Blood cells numerous; connective tissue shreds small and few; salts absent; casts of all kinds and sizes.

*Acute Suppurative Nephritis.*

Urine decreased; specific gravity decreased; large number of pus cells and connective tissue shreds.

Blood cells numerous; no fat.

Epithelia from kidney predominate.

*Acute Suppurative Pyelitis.*

Epithelia from pelvis predominate.

*Chronic Suppurative Nephritis.*

Blood cells few or absent; fat present.

Epithelia from kidney predominate.

*Chronic Suppurative Pyelitis.*

Epithelia from the pelvis predominate.

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VAGINAL HYSTERECTOMY IN THE LATE MONTHS OF PREGNANCY.—Lobenstein (New York) says we possess in this operation one that will in competent hands and under proper conditions tend to lessen both maternal and fetal mortality in a number of the more serious complications of pregnancy. We are all aware of the part played by the rigid os in raising the percentage of both maternal and fetal deaths. According to Scitz, 65% of still births during labor in Germany, died from trouble with the cervical soft parts; 35% directly, and 30% secondarily to other complications, as eclampsia, placenta prævia, etc. In Germany alone 16,000 infants die each year from primary cervical difficulties. These figures are, and surely call for improvement in our obstetrical technic, in at least some directions. The author believes the indications will not arise frequently, except in large clinics with abundant material. When called for, the operation will prove of great value. We should ever remember the prerequisites for success, viz., skill in vaginal surgery, proper surroundings, abundance of good light, and at least two competent assistants.—*Amer. Jr. Obs.* Vol. 65-773.

## THE PROPHYLAXIS AND TREATMENT OF POST-OPERATIVE INTESTINAL STASIS.

BY

FRANK T. BASCOM, M. D., ROCHESTER, N. Y.

(Read before the New York State Homœopathic Medical Society.)

INTESTINAL stasis is a very common post-operative complication. It is most troublesome to the surgeon, highly discomfoting, and at times fatal to the patient. With intestinal stasis there is usually an accompanying gastric distention with dilatation. No attempt will be made in this paper to separate the two, and they will be discussed as one. This paper is the result of an extensive observation of this condition and a little personal experience. It offers nothing new or original; but professes to be a compilation and analysis of certain factors, both pre-operative and operative, which, if recognized in our abdominal surgery, will tend to reduce post-operative stasis to a minimum.

For the purpose of discussing this subject logically, it is deemed best to classify these etiological factors as: 1, individual; 2, reactionary; 3, toxic; 4, traumatic; 5, mechanical.

By the individual factors, I refer to intestinal indigestion of purely functional origin, and to ptosis of the abdominal organs. From the very nature of these conditions, prophylactic measures are of little avail, for patients subject to these disturbances, suffer greatly from gas whenever they are obliged to go to bed, no matter from what cause. It is to be expected, then, that such patients will have more distention following surgical procedures, than other patients. Surgical operations in this class of patients have given me a great deal of trouble, because of the persistent gas pains and distention.

As the reactionary causes, I include pre-operative catharsis and nerve exhaustion from shock. I am firmly convinced that the pre-operative cathartic unless given 36-48 hours before the time set for operation, gives rise to distention either because of the physiological reaction to purging, or from the added nerve fatigue which the movements and loss of sleep occasion. If it is essential that the entire alimentary tract be emptied, the cathartic should be given the second day before the time of operation, that nature's reaction has had time to pass off, and



peristaltic action has returned to normal. There is no cathartic equal to castor oil. A nice way to cover up the nauseous taste of the oil, is the "beer highball," as follows: a bottle of beer, which is not too cool is poured into a glass at some distance from it, so that there will be a large amount of foam; upon the top of the foam 1-2 ounces of the oil is quickly poured and drank before the foam has had time to settle. Unless the cathartic can be given at the time mentioned, I believe it is much better to allow the patient to have an undisturbed sleep the night before the operation, and the morning of the operation simply cleanse the lower intestinal tract with soap suds enemas. If, as Crile believes, shock is due to nerve fatigue resulting from external stimuli; then, all factors calculated to produce shock should be avoided, hence my plea for reducing any needless pre-operative preparation. The following simple preparation, I believe, reduces pre-operative fatigue to a minimum; shave and full bath the day before, light diet until the evening of the same day, no breakfast in the morning of the operation, enemas in the morning, a pre-operative hypodermic of morphine  $\frac{1}{8}$ - $\frac{1}{4}$  gr. with atropine 1-150-1-100 gr. given  $\frac{1}{2}$  hour before the time set for operation, skin preparation on the table consisting of 1-1000 tr. iodine in benzine to remove nature's oil from the skin, followed by an application of 5 per cent. tr. iodine.

The toxic properties of general anesthetics must be considered as an exciting cause of post-operative stasis. All doubtless have had operative cases suffer from distention where no abdominal incision had been made. This is not at all strange when we consider the paralysis of motor functions which anesthetics produce, and realize the length of time before the eliminating channels can get rid of it. Therefore, the degree of distention will depend somewhat upon the amount of anesthetic used. I am firmly convinced that the anesthetist often errs grievously in his endeavor to keep down the amount of anesthetic at the expense of the degree of narcosis, for deep narcosis, if once obtained, can be sustained with but a small amount of anesthetic, so that what really seemed to require a larger amount of anesthetic to accomplish demanded but little more, if any, in the end. This deep surgical narcosis, too, gives the surgeon an unhampered field for operation, without the necessity of continually fighting the intestines, much to their detriment, and the operation can be more quickly accomplished be-

cause of the increased facility of operating due to complete muscular relaxation. It would seem that nitrous oxide-oxygen anesthesia besides lessening shock might aid in diminishing distention because of its lesser toxicity. My own experience with this anesthetic, though limited, leads me to say that I can not get the relaxation for deep pelvic work, where it is so essential unless ether is added. As this paper deals with the "clean case," I do not think it wise to consider the paresis due to bacterial toxins in the "septic case."

The traumatic causes of post-operative intestinal stasis, to my mind, seem by far the most important. The surgeon should be gentle in his manipulations of the tender internal organs, especially as serous membranes are so susceptible to the slightest trauma. The terminal nerve filaments are easily injured, sometimes causing a temporary paresis of intestinal movement, besides often occasioning an exudate of serum which may be provocative of post-operative adhesions. All handling of the intestines should be done with a moistened sponge. If it is necessary to pack back the intestines, because of insufficient muscular relaxation or from fear of soiling the peritoneum in getting up organs in which pus is suspected, I think it is much better to use continuous gauze sponge moistened in saline or warm sterile water, or, better yet, to use a wet towel folded so it is about a foot square, rolling two opposite edges toward each other so as to form two connected rolls. This can easily be inserted with a sponge forceps placing first one end into the pelvis, then the other end into the abdomen at the upper end of the incision, after which the two columns or rolls can easily be spread to either side of the abdominal cavity. I am of the opinion that too much protective material is used in our abdominal cases. I believe the dry sponge should be discontinued, for any length of time becomes glued to the serous surface of the intestines owing to the extraction of fluid. The rough use of retractors produce trauma. Generally the holding of the retractors is delegated to the most inexperienced nurse, who, as a rule, is unable to see what she is doing and has no knowledge of the injury that may be inflicted by their improper use. If a retractor is deemed necessary, it should be one of the self-retaining variety. The incision should be ample to allow unhampered work without the pulling which retractors provoke. If iodine is used for skin preparation, its removal before the peritoneum is opened, is imperative; for I believe chemical trau-

ma through its action on the serous coat of the intestine is a factor to be considered in the formation of post operative adhesions.

The mechanical causes are post-operative adhesions resulting from uncovered raw surfaces, from serous exudate from trauma, or from the reforming of fresh adhesions from the breaking up of old ones. Hence all raw surfaces should be covered, if possible, by suture of the peritoneum, or with tabs of omentum. Where such is impossible, a bland sterile oil sopped on, or aristol dusted on, seems to aid in preventing their formation. So-called Lane's kinks, whether of the cecum or of the sigmoid, should be corrected. Just before the incision is closed it is a good plan to straighten out the intestines, especially the sigmoid endeavoring to replace them in their normal position. Lastly, the omentum should be brought down over the intestines as a protective covering.

The treatment of post-operative stasis consists in forestalling shock by the "rectal hot bottle" method of Clark, while the patient is on the table and in the Trendlenburg position, when a quart of saline at the temperature of 110 degrees F. can quickly be given, and is absorbed before the patient recovers from the anesthetic. Later the drop method of Murphy may be continued. These procedures also aid the elimination of the anesthetic. Formerly it was our practice to use eserine only in septic cases for increasing peristalsis; of late we have been using it in clean ones as well, giving 1-60-1-40 gr. by hypodermic injection as the patient leaves the table, repeating every three hours for three to four doses. We have never seen any untoward symptoms resulting from its use, but it has seemed to be of benefit in relieving gastro-intestinal distention.

Lavage is especially of use in acute cases where vomiting is a prominent symptom; using it before the patient is removed from the table. It is of inestimable value during the first, second and third days when gastric distention is present. It is surprising the amount of bile-stained fluid, which, at times, is drawn off from the stomach in such cases. Rather than resort to the so-called gas enemas; such as, epsom salts and glycerine, turpentine, or alum, it has been our practice to use the milder and equally as efficient rectal irrigation through a Kemp tube, or any other return flow irrigator, using either plain water, saline or water to which one dram tr. asafœtida to the quart is added. This may be continued for an hour at a time or longer



if it does not fatigue the patient. Our objection to the gas enema is the weakening effect which it entails because of its drastic action. External applications in our hands have accomplished little. Gentle massage, at times, aids in expelling the gas. If it is necessary to use a narcotic for post-operative pain, we have practically discarded morphine, and use suppositories of svapnia 1 gr.-2 gr., depending on the age of the patient. We are of the opinion that their use is attended with little, if any, reactionary effect.

Enterostomy, once popular, has to be resorted to but infrequently, owing to present-day methods of treating post-operative intestinal stasis; occasionally, however, it is a life-saver.

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### ELECTRICAL TREATMENT OF SOME OF THE MORE COMMON SKIN ERUPTIONS.

BY

WILLIAM F. BAKER, M. D., PHILADELPHIA.

*The method of application is as follows:*

One large electrode is placed on an indifferent spot of the body.

The other applying electrode is placed directly over the inflamed area and the current controlled by means of a rheostat until relief is experienced and this continued for from five to six minutes.

I use descending galvanic currents in these cases to the inflamed nerve. The anode centrally and the kathode peripherally.

Aconite, iodine, etc., by cataphoritic action have been of invaluable service.

In treatment of skin diseases electricity may be used in two different ways.

1. General application.
2. Local application.

The general application restores to the skin its normal circulation through stimulation of sensory nerves, thus improving all trophic conditions.

The local application is for the relief of pain, hyperesthesia, itching, etc.

Electricity may be used for its chemical action, depositing either acids or alkalis on the skin.

Either the static, faradic, or galvanic may be employed.

Static electricity is recognized as one of the greatest aids to metabolism, especially in the skin and at the same time a powerful stimulant and sedative.

The galvanic current produces a sedative effect if a mild current two to five m.a. be used for three to five minutes without interruption.

The cataphoretic action of the galvanic current may be used to carry drugs under the skin. The anode should be saturated with the drug and applied directly to the diseased area. There is no better application for parasitic diseases of the skin than this.

Gartner proved this of mercury.

Gautier proved it for copper in lupus, actinomycosis and sy-cosis.

The electrolytic action of currents also demands our attention.

Acids liberated at the positive pole coagulate the albumen, thus protecting the surrounding tissues from acid.

The cathode liberates the free alkali; does not coagulate albumen and act as a destructive antiseptic.

These distinctive actions are beyond a question of doubt and their therapeutic action can readily be reasoned out.

Either a gold or platinum electrode should, however, be used and this carefully protected by proper insulation, otherwise an indelible stain of the skin would result.

A brief review of electro physiology might be in order.

We recognize the area treated as an "area of influence" and all surfaces not lying between the electrodes and in the path of the lines of electric motive force must necessarily lie outside this area of influence.

The lines of force pass from the higher to the lower potential and are proportional in their crowding to the size of electrode.

This last law must be thoroughly understood and given proper consideration.

I. ACNE.—This most distressing of all skin affections in the young offers a most useful field for the use of electricity

and it was in the treatment of this condition that my attention was particularly attracted.

Before beginning electrical treatment, however, care should be taken to remove all exciting causes, among the most frequently found I would mention, in order of frequency of cases:

- (1) Seborrhœa of the scalp.
- (2) Gastro-Enteric disturbances, chiefly of the atonic type.
- (3) Local infections by means of fingers, of patient tampering with "pimples."
- (4) Pyæmic conditions of mouth and teeth.
- (5) Menstrual disturbances.

The routine treatment after removal of the exciting cause is the application to the affected area of an intense white light until the skin is moist and slightly sweated. Then the introduction of the violet or purple screen shading the parts in a blue light and allowing them to remain under the application for from 20 to 30 minutes.

II. RING WORM.—For the treatment of this condition my preliminary steps are the same as acne, i. e., getting the skin thoroughly moist, and with a good peripheral circulation.

III. SEBORRHOEIC ECZEMA—associated with scaling.

IV. SKIN MANIPULATION in diseases of periptival nerves.

There is undoubted evidence of diminished irritability by the application of the galvanic anode.

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## SEPTAL DEVIATIONS.

BY

GEORGE W. MACKENZIE, M. D., PHILADELPHIA.

(Read before the Germantown Homœopathic Medical Society, November 18, 1912.)

THE frequency with which it is found, its etiologic bearing, both direct and indirect, upon the local and general health of the patient, the ease of diagnosing and correcting it, and the results obtained from its correction permit us to assign to the subject of septal deviations a place of first importance in the field of Rhinology. For these very reasons the rhinologist could not select a fitter subject for discussion before a society composed mostly of general practitioners.

There are two general types of septal deviations (a) the



developmental which comprise by far the greater number, and (b) the acquired.

The etiology of the developmental type is a problem not definitely settled for there are several theories each of which is plausible and all conflicting. I have already alluded to the subject in a former paper read before the Philadelphia Academy of Medicine, 1909.

The etiology of the acquired form is traumatism; for instance, a fall or blow on the nose resulting in fracture that has been neglected or maltreated.

Each of the two types present certain characteristic features. In the developmental type we find that the septum is buckled, so to speak. It appears as though there was too much septum for the space allotted to it. As a result the greatest amount of crumpling takes place along the suture lines or near and running in a direction parallel to these lines.

When this surplus bone or cartilage piles up along the suture lines we have a spine or ridge with proportionately less buckling of the remaining parts of the septum and vice versa. In some cases where the septum has developed out of proportion to the space allotted to it, to an even greater extent, we find a combination of spine and buckling. The spine and convexity of the buckling is found usually on the same side running in an oblique direction from down and in front to backward and upward. Occasionally the spine may be found on one side and the convexity of the buckling on the opposite. In some cases we find that the crumpling process causes a double bending of the septum resulting in the so-called "S" formed deviation with one convexity high up on one side and a second convexity low down on the other. So we may go on describing various combinations and overlappings that may be found in individual cases, however, all resulting from the one physical cause, i. e., too much septum for too small a space.

I might mention too that there are rarer varieties of deviations to be found which result from bending of the septum along or about the suture between the posterior edge of the quadrangular cartilage and anterior edge of the perpendicular plate of the ethmoid.

In the acquired types resulting from uncorrected fractures, there is found a deviation, the long axis of which runs in a direction at right angles to that of the force which produced it. Besides, as in the case of fracture of bone or cartilage else-

where we find angular deformities or overlappings of the fractured edges accompanied with hyperostoses.

The symptomatology of septal deviations depends largely upon their extent and location and too, upon presence or absence of accompanying pathologic conditions. A very slight deviation in a subject with wide nasal chambers may produce but little or no inconvenience; on the other hand, when the deviation is pronounced it may produce many unpleasant symptoms and complications referable to the nose and elsewhere, among the more common of which may be included the following:

By narrowing the breathing space usually of the convex side, but occasionally of both sides in cases of "S" formed deviations there is produced *impairment of nasal respiration* and consequent *mouth breathing*.

By pressure of the deflection, immediately, upon any part of the lateral nasal wall there may occur *neuralgia*, continuous or intermittent.

By interference with the proper ventilation of the accessory sinuses there is produced a negative pressure within the sinus, causing *headaches*.

Secondary conditions of the nose and adnexa may be favored or produced, indirectly, as follows:

By improper breathing and insufficient ventilation of the nasal chambers the patient is made more susceptible to "*colds in the head*" and other *infections of the nose*. This is amply proven by the fact that patients almost invariably give the history of fewer colds after the correction of their deviation than before.

By delaying the recovery from "*colds in the head*," the deviation favors the development of *chronic catarrhal rhinitis* with accompanying hyperplasias of the mucous membrane to be followed later with secondary atrophy.

By improper warming, moistening and filtering of the inspired air is favored the development of *pharyngitis*, *laryngitis*, *bronchitis* and *pneumonia*.

By improper ventilation of the accessory sinuses is favored the development of subacute or chronic catarrhal or purulent *sinusitis*. The relationship of pronounced septal deviations to accessory sinus disease is much like that of adenoids to middle ear disease. We might conveniently add, here, to the diseases of the accessory sinus such dependent conditions as nasal polyps.

By contact of the deflection with neighboring parts is favored in certain hypersensitive people *hay fever* and *asthma*.

By exposing certain portions of the septum to the too direct influence of the inspired air is produced a condition of metaplasia and atrophy of the exposed mucous membrane with resulting *crust formations* and *hemorrhages*, the so-called *Locus Kisselbach*.

By interfering with the nasal respiration it contributes to pathologic conditions of the middle ear according to most authors. My own experience bearing on this point shows that of the unilateral cases of catarrhal deafness, the vast majority show the ear corresponding to the side with the greater nasal obstruction to be the one involved.

By pressure or otherwise it may cause reflex asthenopia pointed out by M. L. Foster in a paper on "Reflex Asthenopia, from Intra-nasal Pressure," *Annals of Ophthalm.*, Oct., 1909, and others and noted by the writer.

Septal deviations may disturb the patients' general health, producing abnormal conditions, for instance:

By reason of imperfect nasal respiration *under-development*. As proof of this we find not infrequently that a puny child will increase in weight, strength and vigor after an operation for the correction of the septal deviation. The same change, but to a less degree may be noted in adults. It not infrequently happens that a young adult will add several inches to his chest measurement and from ten to twenty pounds to his weight.

The ill effects of imperfect nasal respiration upon the general health have been proven by animal experiments, upon dogs and other animals, and set forth in an able paper containing many photographic illustrations by Dr. Willis S. Anderson, which appeared under the title "Experimental Study of the Effects Upon the Respiratory Organs and the General System." *Annals of Otology, Rhinology and Laryngology*, Sept., 1909.

Because of imperfect nasal respiration and the sensation of increased intra-nasal pressure we find not infrequently *mental hebetude* even more pronounced than in those afflicted with adenoids.

I have included only those most direct and a fewer of the least indirect conditions that are dependent on septal deviations.

When we consider the combination of septal deviations with



other more or less dependent intra-nasal conditions the resulting possibilities of disturbance to the general health are multiplied.

TREATMENT.—The only rational treatment of septal deviations is their mechanical correction; furthermore, since in septal deviations we have a condition where there is too much septum for the allotted space the logical procedure is to select that method of operation which is best fitted to reduce the redundancy of cartilage and bone and at the same time preserve the septum intact. The one operation that fulfills these requirements is the so-called Killian method of sub-mucous resection. The superiority of this operation has been verified by practically all rhinologists. The sub-mucous resection can be accomplished with greater celerity, with less pain and shock to the patient than any other operation for the correction of septal deviations, besides the healing is decidedly quicker, the matter of a few days as compared with that of several weeks by the older methods.

I will not occupy your time with a description of the operation, which of itself would take up a whole evening.

The presence of any one or more symptoms or conditions outlined in my paper is sufficient indication for the operation. Concerning the contra indications, excepting as to the choice of time, I know of none. I would not advise operating on the septum in the presence of an acute infection in the nose. It is better to wait until the infection has subsided.

The results of the operation speak for themselves. In a general way, I wish to say that I know of no operation on the nose or throat where the results are so uniformly gratifying.

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THE INFLUENCE OF CHRONIC METRITIS AND CYSTIC DEGENERATION OF THE OVARIES IN CAUSING UTERINE HEMORRHAGE.—Schickele and Keller have also studied this subject for the purpose of determining the relationship between hemorrhage and the relative amount of muscular and connective tissue present in the uterine wall. The quantity of each was estimated in a laborious and painstaking way. The results showed that where there existed in the mucous membrane no explanation for the hemorrhage, neither could it be found in an insufficient development of muscle or in a preponderance of connective tissue. The variations in the histological structure of the uterus are not competent to explain pathological hemorrhages, so that the present conception concerning chronic metritis must be abandoned.

In a number of cases also the ovaries were examined and in none of them was small cystic degeneration found. The authors believe that the anatomical changes in the ovaries do not explain the uterine hemorrhage.—*Arch. f. Gyn., Vol. 95, 609.*

## Transactions of the Homœopathic Medical Society of the State of Pennsylvania.

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BUREAU OF HOMŒOPATHIC INSTITUTES AND CLINICAL  
MEDICINE

O. H. PAXSON, M. D., Chairman

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### IS A PHYSICAL EXAMINATION ESSENTIAL FOR THE SELECTION OF THE HOMŒOPATHIC REMEDY?

BY

JOHN A. FISCHER, M. D., PHILADELPHIA.

(Read before Homœopathic Medical Society of the State of Pennsylvania.)

A BEGINNER in the study of homœopathic therapeutics is usually impressed with the fact that all that is needed in the selection of a remedy is the totality of symptoms. This opinion is also held by many members of our profession.

Hahnemann, in his *Organon*, says, "The totality of the symptoms is the only indication and the only guide to the selection of a remedy." Further, in paragraph 84, he describes what he means by this totality: "That the patient details the history of his suffering. Those about him tell of what they heard him complain, how he has behaved and what they have noticed in him. The physician sees, hears and remarks by his other senses what there is of an altered or unusual character."

Are we to infer from the latter sentences that he refers to a physical examination? I believe not, for when we refer to paragraph 14 of the *Organon*, we find the following quotation:

"There is in the interior of man, nothing morbid that is curable that does not make itself known to the accurately observable physician by means of morbid signs and symptoms."

We are, therefore, led to suppose, in the days of Hahnemann that symptoms and morbid signs were the all sufficient basis for the selection of the remedy. I believe that, to-day, with our advanced and almost positive knowledge of diagnosis,

pathology, bacteriology, surgery, etc., we are better equipped to prescribe in accordance with the law of similars.

How often have we prescribed for a patient after listening to a few symptoms, and how often, do we fail, charging the remedy or possibly homœopathy with our failure?

My most satisfactory results have been in those cases in which I have made a careful physical examination, in addition to eliciting the patient's history, and this not only aids in the selection of a remedy, but also in the differentiation as well. We are also better able after such examination to know if the case is suited for a dynamic remedy. For most of our disappointments are due to expecting impossible things of our remedies. There is a limit to their usefulness and the sooner we find this out the better will be our results.

In order to illustrate some of these points I will cite a few cases that have come under my care:

CASE 1.—Mr. H., age thirty-five, consulted me for what he called rheumatism of his left hip. After presenting his diagnosis which, he said, was made by twenty different physicians, he gave the following history: When a young man he lived in Vermont. One day while driving through the snow, his horse fell, and in helping him up he hurt his back. He was compelled to go to bed and sent for his physician who made a diagnosis of rheumatic fever.

On making my examination, I found an ankylosis of four dorsal vertebra, the eighth to the eleventh. Over this area were also found a number of scars. These, he claimed, were due to abscesses caused by his rheumatism. I further ascertained that, periodically, he would develop an abscess in the left groin which would drain profusely. A diagnosis of osteomyelitis of the spine was made. Silica 6x was prescribed, and effected a cure in less than six months.

CASE 2.—Mr. S., age twenty-four, shipping clerk. Sick about three years with periodic attacks of severe griping pains, starting at the umbilicus and shooting into the penis. Examination revealed a slight rise of temperature, pulse rapid, abdomen rigid, splashing on palpation, change of position altered percussion.

Diagnosis of traumatic peritonitis was made. Bryonia effected a cure in a few days.

CASE 3.—Mr. D., age twenty-eight, confectioner. Had not been able to smell for ten years. Been under treatment by



several physicians for chronic catarrh, which was supposed to be incurable. The removal of a number of nasal polypi from each nares completely restored his smell. Sanguinaria was prescribed to prevent their further formation.

In closing, permit me to state my conclusions which are as follows:

First. A physical examination is essential to accurate prescribing in order to obtain the actual totality of symptoms.

Second. A physical examination is essential in order to determine the cause of the diseased condition and to enable the prescriber to remove that cause if possible, in accordance with the teachings of Hahnemann.

Third. A physical examination is essential in order to determine whether the case comes within the scope of a dynamically acting remedy, or whether some physical or mechanical therapy is indicated.

#### DISCUSSION.

WM. R. WILLIAMS: It is just possible that a physical examination is not necessary for the selection of the homœopathic remedy but, certainly, it is necessary to an intelligent selection. The making of a careful and complete diagnosis will save many moments of disgust with our homœopathic remedy and save the homœopathic practitioner from criticism. It is important to determine the entire status of the departure from normal of the function of that patient. Sometimes there are many abnormal conditions: chronic bronchitis is an example of this fact. We may have a man of fifty or sixty years old with a cough that disturbed him and the whole household and if we are only interested in selecting the remedy, we may try a number and after failing with these, we may examine him further and find that he has thickened arteries, high blood pressure and possibly a dilated heart or diseased kidneys; a high proteid diet and faulty elimination may be at the root of the whole matter. The further we go in the examination, the more absurd it seems to stop at the selection of the remedy. The regulation of the diet, the assisting of elimination and the toning up of the heart are all important factors in restoring the patient to a normal condition.

DR. W. D. BAYLEY: In the "Organon" Hahnemann stated that what is to be cured in disease consists in the complaints of the patient and the morbid changes in his health perceptible to the senses; that these together, constitute the totality of symp-

toms. A prescription is therefore to be based on both subjective and objective symptoms. That this was his intent cannot be questioned.

Dr. Fischer's paper emphasizes the two chief duties of the modern homœopathic physician. First, the making of a complete diagnosis by all the methods at hand, and, second, the planning of the appropriate treatment. How essential a physical examination may be for the mere selection of the homœopathic medicine might be open to question, but there can be no doubt that diagnosis based upon a thorough objective examination is essential for the planning of the entire treatment of the patient. The determination of the collateral treatment may depend entirely upon the physical findings. When confronted by a new patient it is best to keep the mind blank on the question of treatment until a diagnostic examination is made. Make the examination first—plan the treatment afterward. Diagnosis is made by a *synthetic* use of symptoms; that is, we piece together the objective and subjective phenomena presented by the patient into a clinical picture. On the other hand, a homœopathic remedy is found by the *analytic* use of symptoms. That is to say, they are taken apart from each other so that they may be matched up by reference to corresponding symptoms produced by drugs. These two mental processes are so unlike each other that in making a patient's record the last should not begin until the first is completed.

DR. H. G. CARMALT: I want to thank my colleague for his insistence upon the physical examination. A woman came under my observation who was pronounced hysterical and had been under treatment for three years, first by an old school physician who has done very good work, and, second, by a homœopathic physician who tried to make a cure by a homœopathic remedy but failed. I took the case and was told by the family that it was a case of hysteria. I went over her carefully and recommended that she see a surgeon and have her gall bladder operated upon. As the result of the operation we took out one hundred and forty gall stones and after that the homœopathic remedy helped the patient get rid of her gnawing nervous symptoms.

DR. LANDIS: It seems to me that Hahnemann teaches us that we shall take the totality of symptoms, and goes so far as to say we shall observe all we can before we make any diagnosis and we must also have a thorough knowledge of the mental and physical examination of the patient.

## ABDOMINAL PAIN IN DIAGNOSIS.

BY

GEORGE P. STUBBS, M. D., PHILADELPHIA.

SINCE the celebrated episode of Eve and the Apple, pain has been the common inheritance of humanity. History fails to record a time or period blest by the absence of jumping nerve and griping colic. Journalistic medical science and newspaper medicine has aroused the public interest in many varied branches of our art, and knowledge is being slowly crammed, *wille nille*, down the intellectual throat of the laity. But upon the introduction of pain to the average mortal his interest bounds at once into a lively activity. He will contemplate with equanimity the cavity in a tooth until the advent of pain, upon which he starts after the dentist with the eagerness of a bill collector. We bear with spartan stoicism the signs of an overtaxed nervous system until we have developed a neuritis, and forthwith are we keenly sorry and would reform.

A pain is very much like a person. Some pains are straightforward and honest, others are shifty, unsettled and always trying to blame someone else. Among the former are most of the surface pains definitely locating the source of the trouble, while internal pains are apt to be referred through the sympathetic system to distant organs.

In considering the subject of pain in the abdomen one is immediately impressed with the variability of this symptom. We meet with cases in which the pains point distinctly and unequivocally to the source of the trouble, in which the localizing power of the pain is of great assistance in making a diagnosis. Such is often the case in appendicitis, gastric ulcer, and pelvic diseases. On the other hand, it happens not infrequently that the pain symptoms, not content with being indefinite, are actually misleading. Especially is this so in the early stages of the disease when a correct diagnosis is most desirable. Confusion and uncertainty is the inevitable result of such variations in abdominal pain unless the underlying cause is held clearly in mind.

A glance at the nerve supply of the organs and membranes under discussion may furnish a clue to many an otherwise obscure symptom complex. For practical purposes we may consider the peritoneum as composed of



two portions — the *parietal portion* lining the anterior and lateral abdominal walls, and the *visceral portion* covering the various abdominal organs and having its limit at the root of the mesentery, and the meso-colon and meso-sigmoid. This seemingly arbitrary division of a continuous membrane appears the more natural as we consider the neural supply of the peritoneum, the importance of which lies in the fact that nearly all abdominal pains are the expression either of irritation or inflammation of this very complex membrane.

The first, or parietal portion of the peritoneum, receives its nerve supply through those distributed to the muscles and skin of the abdominal walls, namely, the lower seven intercostals, the ilio-hypogastric, and ilio-inguinal branches of the first lumbar nerves. Branches from these penetrate the muscles and ramify in the parietal peritoneum. Being nerves of sensation as well as motive, any irritation of the peritoneal terminus is at once transferred to the muscular terminals, and a contraction of the abdominal wall results. Being similarly associated with the lower intercostals, we find irritation of the parietal peritoneum causing interference with the intercostal muscles, and we have rapid, shallow breathing. It is well to bear this effect in mind as the condition has been mistaken for a pleural or pneumonic inflammation. In this connection it will be recalled that, because of this nerve association, pneumonia is sometimes ushered in by severe abdominal pain accompanied by rigidity. This is especially apt to occur in children.

Because of the very close connection between the parietal peritoneum and the abdominal muscles, rigidity of these muscles furnishes a quite reliable guide to parietal peritonitis, when the contracture is local and marked, and when, as is usual, it is accompanied by localized pain also. On the other hand, if the contracture is general and less intense it is apt to be the result of reflex from a more distant portion. This we will consider in a moment.

It will sometimes be noted that a case of peritonitis will exhibit an exquisite tenderness which will not admit of even the lightest touch, as of a sheet, on the abdomen. Such a touch could not possibly hurt the peritoneum and is explained only by the skin irritation causing muscular contracture which in turn produces peritoneal pain. In making abdominal incisions it is, therefore, well to remember the general downward and forward trend of the nerves of the abdominal wall and thus avoid cutting

them. To do so is to weaken the protective action of the abdominal muscles, as well as render them liable to stretch under intra-abdominal pressure.

The second portion, or visceral peritoneum, is distinctly more complex both in its contour and its nerve supply. Intimately associated with the organs it covers, this portion of the peritoneum receives also its nerve supply mainly from the branches of the solar plexus, itself the result of the union of the sympathetic, pneumogastric and phrenic nerves. By means of the short rami communicantes these sympathetic ganglia are connected with the lower thoracic and intercostal nerves. It will be remembered that, excepting the last named, these are nerves of function rather than of sensation. Were it not so our digestive and intestinal activities would be periods of great distress.

We can, therefore, epitomize the above by saying that the parietal peritoneum is well supplied with nerves of sensation, while the visceral peritoneum has none directly connected.

It was doubtless due in large measure to this variable quality of abdominal pain that skill in diagnosing the diseased conditions here met was but slowly acquired. The concentration of the professional mind upon appendicitis, McBurney's point pain, rigidity, etc., has been productive of much good in assisting to early diagnosis. But it is not to be forgotten in view of the anatomical conditions, that these symptoms are not always available, and the diagnosis must be made, if made early, without their aid.

Take the case of perforating gastric ulcer. It is not so much the pain of perforation, but the parietal peritonitis immediately set up which leads to early diagnosis. Gastric perforation is not infrequently diagnosed by the post-mortem route, because disguised by its remoteness from the parietal peritoneum.

Mrs. D. V., dying of acute uraemia, was subjected to post-mortem examination and, beside the kidney lesion, found to have an old cicatrized gastric ulcer which had perforated and caused peritonitis with extensive adhesions between the stomach and liver near the pylorus. This patient had long suffered with what was recognized as an ulcer, but had never had an attack presenting the usual symptoms of perforation. The only explanation of the findings seems to be the placing of the perforation so remotely from the parietal peritoneum and consequently from nerves of sensation.

In a recent article by Dowd there is mention made of two cases, one a typhoid perforation and the other a traumatic rupture of the sigmoid, in which the symptoms were inadequate for the forming of a diagnosis until a general peritonitis had developed. In both cases pain and rigidity were absent by reason of the injury being surrounded by coils of intestine and thus for a time protecting the sensitive portions of the peritoneum.

In the same manner it is quite possible for perforation of the appendix to occur unannounced by preceding pain, rigidity or tenderness, when the organ lies deeply and toward the median line. This was illustrated aptly in the case of Miss H. P., aged 17 years, who was ill for two days with what was considered acute gastritis. Vomiting, vague epigastric distress, moderate fever, with a complete absence of abdominal pain or rigidity, led two surgeons to concur in the diagnosis of gastritis on the afternoon of the second day. That same night a rapidly developing state of shock called for exploratory incision and I found the appendix deeply placed toward the midline and enclosed in coils of intestine. It was ruptured, gangrenous and surrounded by about two ounces of putrid fluid. In this case the pain was all reflexed to the epigastrium, and the parietal peritoneum presented no evidence of inflammation.

Before the American Medical Association in 1911, Mitchell, of Washington, made some interesting observations on this subject. While doing a cocaine operation on a physician he obtained consent to make certain tests the nature of which were unknown to the patient. He says in part: "He was anxious to watch the operation and see his appendix in place, and so was allowed to have his head raised for this purpose. The appendix presented readily at the opening of his unusually thin abdominal wall. It was clamped across and caused no inconvenience. Then by making traction on the mesentery I could at will cause him to sink back with marked pallor, nausea and complaint of violent pain in the epigastrium, which he described as 'my old friend.' These phenomena disappeared when the mesentery was released, and he was able to watch the completion of the operation."

This manifestation would seem to be quite in line with the patients known to all of us, whose complaint is that they cannot lie long in some particular position because of pain produced and a drawing or pulling sensation, evidently due to



traction upon the mesentery, meso-colon or adhesions thereto. Very commonly is this met with after operations. In the same manner is intestinal colic produced, violent peristalsis supplying the traction upon the mesentery. Mitchell concludes in the above mentioned paper that "true protective muscle spasm comes only from inflamed parietal peritoneum."

The action of referred pain in abdominal lesions is well illustrated in the so-called appendical dyspepsia which is just at present receiving much attention. In this condition local pain and rigidity are often conspicuously absent, but in their place we have a persistently recurring or even constant gastric distress, fullness after meals, or other symptoms of gastric atony. Such a symptom complex resisting all rational treatment of gastric disease, will probably find its explanation in a chronically inflamed appendix or a rectal ulcer.

It is readily understandable how such a functional disturbance started by a reflex irritation, may eventually develop a gastric or duodenal ulcer, a cholecystitis or even favor the development of a latent carcinoma. Barclay, of New York, reports 41 cases, all referred as chronic indigestion and all entirely or almost cleared up by the removal of the appendix.

Beside the disturbance of function caused we must recollect the tendency to over-development of fibrous, and destruction of lymphoid tissue inherent in the appendix, thus forming an "inert breeding ground for micro-organisms," and a nidus of infection. Moynihan in twelve consecutive cases of duodenal ulcer removed the appendix and found it diseased in each instance. (*Lancet*, Jan. 6, 1912.)

McCarthy (*Annals of Surgery*, Dec., 1910) concludes that low grade "chronic inflammation in the appendix disturbs reflexly the gastro-duodenal hepatico-pancreatic physiologic systems, thus being a predisposing factor in gastric and duodenal ulcer, gastric carcinoma, cholecystitis, cholelithiasis and pancreatitis."

The point that touches us at the present moment in all this is that the cause lies hidden in one portion of the abdomen while the result is manifest in another. Pain, indeed, in these conditions is not so much a symptom as a sequence of disease. The early absence of painful manifestations in gastro-intestinal carcinoma (largely the result of non-sensitive nerve involvement) leads Wm. J. Mayo to express himself as follows in a recent number of the *Journal-Lancet*, "The pessimism of

the medical profession regarding malignant disease of the gastro-intestinal tract is not justified by the facts. It is the failure to make diagnosis during the stage when the disease is still localized, and not any peculiar malignant tendency of the process itself, which accounts for the fatal character of cancer in this region."

The important bearing of referred pain or absence of pain in abdominal diagnosis could be amply illustrated, but one case will suffice. In the spring of 1910, Mrs. J. V., aged 62, was referred with a history of chronic indigestion. The past year she had been rendered a semi-invalid by vague epigastric distress, worse after taking food, a growing tendency to diarrhoea and practically nothing else. Gastric content tests shed little light upon the case and exploratory incision was advised. A high incision through the right rectus revealed after some searching a circumscribed area of hardened and contracted tissues enclosing the small intestine. This portion of the tube was excised, with a complete cure of the so-called indigestion, and an uneventful recovery. The tissue showed proliferated fibrous tissue and evidence of advancing carcinoma.

Conditions and cases such as those cited justify the conclusion, first, that pain in abdominal diagnosis is reliable as a localizing symptom only when the parietal peritoneum is involved; second, that the absence of pain and rigidity is not evidence of absence of abdominal disease of grave type, and third, that if a diagnosis is to be made early it must frequently be made without the help of these two symptoms.

#### DISCUSSION.

DR. N. F. LANE: It is unfortunate from a diagnostic standpoint that we cannot always locate a pathological lesion in the abdomen from the situation of the pain. For instance, in pelvic lesions we are apt to have epigastric pain two or three days, often it localizes in the lower abdomen. This also occurs in appendicitis. The matter of cutting the nerve supply of the abdominal muscles is a very important one. When we make our incisions in the middle line we usually have no trouble; when we cut in the lateral regions we are apt to weaken the muscles.

DR. WILLIAM R. WILLIAMS: I know of nothing from the standpoint of the internist that gives more trouble in diagnosis than abdominal pain. I have formulated one rule, and that is

never to treat a belly-ache over the telephone. Abdominal pain does not quickly subside. It brings up immediately the question of surgical intervention, and it is that which gives the physician trouble. I had a case last winter, a woman who had had typhoid fever and after getting up had pain about the umbilicus and back. There was no tenderness or rigidity over the abdomen; her temperature was slightly subnormal; there was no evidence of shock, pulse was sixty. The pain was only controlled with morphia, temporarily, and I was convinced of the need of surgical operation. I had one of the best surgeons of our school see her, and after twelve hours he stated that he saw no necessity whatever for opening the abdomen and that he considered it a medical case. Shortly afterward the pulse jumped from sixty to one hundred and forty and the abdomen became distended. Examination disclosed tenderness in the lower right quadrant. Six hours afterwards the abdomen was opened and eighteen inches of gangrenous intestine was found. The process had gone so far that the peritoneum burst and the free fluid in the abdomen contained the contents of the bowels. If abdominal pain does not subside quickly it had better be looked upon as a surgical condition.

DR. MARY RIDGWAY: I would like to urge a more thorough examination of children. I believe a large percentage of children have appendicitis. Many children complain of pain and I believe their abdomen should be carefully looked over and examined. I usually locate irritation in the appendix by using the little finger and, in a paper recently prepared, I have enumerated twenty-eight diseases that appendicitis might be confused with.

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NEUROPATHIES AND PSYCHOPATHIES OF GENITAL ORIGIN.—Bossi (France) believes that hysteria and many neuropathic and psychopathic conditions, with their resulting suicides and crimes are often dependent upon chronic lesions of the genital organs, especially when of infectious origin, or caused by displacements. Many of the cases cited by him recovered after a careful course of gynecological treatment. It is the duty of the physician to recognize these facts and to treat the conditions, and in this way to prevent crime, undeserved stigma upon the children, and suffering of the patients. Many patients treated with bromides, etc., require gynecological treatment. The author advocates an active propaganda among physicians and the public to teach the undoubted effect of conditions of the genital organs on the nervous and mental symptoms. When crime in women comes before the courts, the patients should be examined to ascertain whether it was not the result of an abnormal genital condition. Insane patients should also be examined and treated in the same way.—*Abstr. Am. Jr. Obs.* Vol. 65-506.



## BUREAU OF OPHTHALMOLOGY, OTOTOLOGY AND LARYNGOLOGY

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W. DE HAVEN EACHES, M. D., Chairman

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### REASONS FOR FAILURE IN THE TREATMENT, AND ESPECIALLY IN THE USE OF THE INDICATED REMEDY, IN DISEASES OF THE UPPER RESPIRATORY TRACT.

BY

CHAS. H. HUBBARD, M. D., CHESTER, PA.

IN response to the solicitation of the chairman of the Bureau of Ophthalmology, Otology and Laryngology, of this Society, for a non-technical paper, your attention is invited to a consideration of diseases of the upper respiratory tract, with special reference to conditions that inhibit successful treatment.

Too often the domination of natural laws seems to be forgotten, and the existence of a vital harmony in man's complex economy is ignored. It is manifestly idle to expect any treatment to be curative when the laws of nature are disregarded and even flagrantly antagonized. The vital relationship existing between the atoms of man's organism, are so delicately adjusted that a slight discordant note in the natural harmony of life's forces, disturb the concord of nature and instinctively throws the organization out of commission. Hence, anything that interferes with the functioning process, produces a correlative degree of organic change corresponding to the character, location and continuance of the interference. As a natural corollary then, it must logically follow that any agent employed to preserve health or cure disease must prove wholly or in part non-effective when the harmony of nature is disturbed. This patent fact should explain—to a great extent at least—why the administration of the indicated remedy not infrequently brings keen disappointment. This latter statement is predicated upon the assumption that the case has been properly taken and the remedy prescribed in accordance with the totality of the symptoms.

Let us consider some of the causes that prevent curative re-

sults in the treatment of diseases of the superior respiratory region, many of which are not difficult to locate or control, but are, nevertheless, too frequently disregarded. First, one should not forget the potentiality of heredity in the great alchemy of nature. The tyranny of one's ancestors is an inheritance to be constantly reckoned with. Again, the matter of environment is not given that consideration which its importance unquestionably demands. Conditions most antagonistic to the maintenance of health are permitted to disport themselves without serious thought or attention. However, under the general head of hygiene and sanitation, the whole question under consideration may be discussed, for therein lies the fundamental basis on which hinges success or failure.

It is a recognized fact—though not always admitted, that the treatment of disorders of the upper respiratory tract, and particularly those of a chronic character, is not universally attended with marked success. In fact, not a few cases are positively made worse by the treatment.

The laity are lamentably ignorant and indifferent regarding the plain laws of right living. And the laws of health and the necessity of their observance require to be hammered in vigorously and continuously.

That departure from the normal which we conveniently designate a "cold," is the one potential factor in the production of diseases in the superior respiratory tract. And all the knowledge and skill known to science must be utilized to prevent the contraction of a cold, and also to secure its prompt elimination when once established. An acute inflammation of the mucosa always works damage, and when the nasal cavities are involved the trouble easily extends by continuity of structure, nervous and vascular relationship to other structures. And each succeeding attack invites future attacks and thus materially intensifies the injury and makes certain a chronic condition. And it is chronic conditions in particular that we shall consider and emphasize at this time.

It is essential that the physician should secure the confidence and hearty co-operation of the patient. He should insist upon regular and systematic treatment. And psychological therapy at the very beginning should play no minor part in the drama. Mental healing is a vital fact and a remedial agent for good or ill that cannot be safely ignored. The patient should banish worry and all gloomy thoughts and look upon the hopeful,

sunny side of life. To advise a patient to avoid "catching cold," and many other equally illuminating directions, is about as valuable—without specific instructions as it would be to tell a patient to avoid overworking his left suprarenal capsule. It is the business of the physician to know, and he should give definite and positive instructions. And, like our remedies, each case needs to be individualized. It is not the purpose of this paper to attempt a consideration of all the details involved, but in a general way invite attention to fundamental principles and conspicuous blunders.

The necessity for an abundance of fresh air and sunshine cannot be too vigorously insisted upon. The colossal number of human house-plants that make an unsuccessful struggle for health, is truly appalling. That the medical profession is not outspoken enough in this matter is too evident for extended argument. The petted child of the millionaire, and the poor offspring of the slums and the sweat-shop are sufferers.

The question of proper exercise for those who lead sedentary lives, is one that requires serious consideration. But some regular, systematic exercise must be insisted upon. For a certain class of such patients, much may be done by the adoption of a system of deep-breathing and the use of friction mits. However, of all the cold-catching invitations invented by man, we are fully persuaded that the one great Moloch of pernicious activity in favoring its production is dietetic. Quantity and character of the food, and the time and method of eating are frequently so conspicuously offensive to nature that she may unreservedly dub them as the chief malefactors. And not until one's eating and drinking is made to conform to the safe and sane laws of nature can cold and resulting catarrhal disorders be prevented or cured. Gluttony is man's worst foe. And if one would quickly and certainly develop a full-fledged "cold-in-the-head,"—which is simply a local manifestation of an outraged metabolism, let him indulge in a night's *debauch*, with all the sensuous abandon which that term implies, and his highest expectations will be realized. Again, without a clean, pure mind, a clean, healthy body is impossible. Careful and honest observers contend that in the examination and treatment of diseases of the nose and throat, those who habitually indulge in gross, erotic thoughts, thereby prostitute the body, weaken the powers of resistance and open wide the avenues to disease and death. This thought cannot be emphasized too strongly. These erotic



debaucheries of mind and body cannot always be detected, but not infrequently this undiscovered abuse is the one exasperating cause of failure; its detection opens the way to a cure.

There are many local conditions that prevent successful treatment, and are especially inhibitory to drug therapy. It seems hardly necessary to mention the deformities and obstructions of the most obvious and pronounced character that exist in the nose and throat, demanding correction before any other remedial effort can expect to be curative. And yet, it is a notorious fact that these abnormal conditions are permitted to continue uncorrected in very many cases, thus bringing unmerited reproach upon the physician and upon the treatment employed.

In considering the exciting causes and perpetuating influences of diseases of the superior respiratory tract, the nose shall have first claim upon our attention. Irritation of the nasal mucosa, by whatever means, causes a retention of blood in the capillaries and is the forerunner of future disorder. Where nose and throat surgery receive proper attention, there are many minor local disorders that are frequently overlooked, but are, nevertheless, disturbing agencies that must be controlled. In this connection we find that even normal secretions within the nasal cavities, if permitted to remain, invite the lodgment of irritating materials from within and from without, causing hyperemia, alteration of tissue, which ultimately develops perverted secretion, unfriendly bacteria, and then still greater structural degeneration. The filth that is harbored within the average nose is too repugnant to speak of, and yet, necessity seems to demand it. Even when the proper toilet of the nasal fossae is attempted, the crude and unscientific methods adopted are often non-effective and at times positively injurious. Local solutions employed are frequently irritating and harmful because of their character or strength, and also to faulty methods. The spray may be injected with too great force, and this is liable to occur when a compressed-air apparatus is used. Again, the antiseptic or cleansing solution is often directed along the floor of the nose or otherwise misdirected, and even when properly introduced it is permitted to immediately flow out again without being retained long enough to be effective, thus utterly failing in its mission. And great harm may be done the ear when the nose is vigorously blown immediately after the use of liquids in the nose. It is a wise procedure to follow a watery application with a bland, oily vapor. The use of the swab in making

drug applications to the nose and throat is greatly abused. An exquisitely inflamed mucosa should be touched most gently, and, in fact, it may be safer to use soothing, non-medicated vapors and the indicated remedy; the results will be better. Not infrequently harm is done by failure to employ warm fluids in the nose, cold being an irritant, while heat reduces inflammation. As a general proposition, medicaments considered beneficial for diseased tissues, are injurious to healthy structures. And yet, how universally they are forced upon normal and abnormal areas without distinction. Nature quickly resents foreign interference, and the indiscriminate use of local applications may do, and often does, more harm than good. In this connection it is well to remember that the antiseptics usually employed destroy innocent and infectious bacteria with equal facility. A mild alkaline solution to thoroughly cleanse the tissues where there is no feter, is infinitely better than pronounced disinfectants. What has been said regarding the nasal fossae, will apply in a large measure to the pharynx, mouth and larynx, though the mouth and teeth must have special consideration—a much neglected phase of the subject. When we recognize that most contagious diseases find their way into the body through the mouth, the importance of that organ becomes manifest. An unkept, filthy oral cavity is the most fruitful source of bacterial infection of the throat, nose and ear. Diseased teeth and gums often cause and maintain a diseased state of the eye, ear, nose and throat. And again, the teeth become diseased from pathological conditions of the nasal structures, the antrum of Highmore, and other communicating cavities and structures. It is safe to assume that no patient suffering from chronic nasal or throat troubles can recover while diseased teeth and gums are permitted to exist. With a clean, healthy mouth, the tendency to tonsillitis, lagrippe, pharyngitis, rhinitis, otitismedia, diphtheria, pneumonia, neuralgia, tuberculosis, etc., is greatly lessened. In fact, perfect health cannot be sustained while the mouth—the gateway to man's organism—is permitted to act as a breeding spot for infectious germs. For here is an ideal culture medium for bacteria, and it is claimed that not less than twenty varieties, many of them dangerous to life, find a habitat in the mouth. While decay of the teeth depends upon both dietetic and constitutional disorders, their health is not maintained in the presence of a neglected tooth brush. The hygiene of the mouth has been too long neglected by

the physician. He should know more about it and pay more attention to it. And the dentist should be more frequently consulted. A deformed dental arch causes deformed nasal cavities. Malocclusion of the teeth, together with other abnormalities of the mouth often require the work of an orthodontist before the rhinologist can effect a cure.

Another important phase of mouth sanitation that receives little or no attention is the preparations of patients for surgical operations, and particularly when the nose or throat are to be interrogated. While the usual precautions to insure surgical cleanliness are observed, the teeth and gums—those germ-incubating structures—seldom receive any adequate attention. Not only the patient, but even the surgeon and the squad of humans about him, exhale pathologic micro-organisms by the millions. While a determined attempt should be made to thoroughly sterilize the mouth of the patient, why not scrub the mouth of all who come near him? A celebrated author has advised the following procedure, prior to a surgical operation: Supply the patient with a new, clean tooth brush and a bottle of antiseptic mouth wash, and instruct the nurse to thoroughly cleanse the mouth every two or three hours previous to the time of operation while the patient is in the hospital and awaiting surgical procedure.

The recognition and employment of scientific facts, other than drug therapa is necessary to a full realization and application of the law of *similars*. It is wholly irrational and illogical to expect the indicated remedy to prove curative in the presence of conditions wholly antagonistic to a cure, and especially when the predisposing and exciting causes are still operative. Unwarranted odium is often cast upon our remedies because they are thrust forward into fields of activity utterly foreign to their nature. The proper remedy will always act, but it must be within the circumscribed area of its own natural and proven law of cure. It is as essential to have accurate drug diagnosis as it is to have diagnosis of disease. Acting upon any other hypothesis is to court deserved failure. In the treatment of diseases of the respiratory tract no less than in other parts of the human economy, the physician should be qualified to summon to his aid all the resources of logic and all that pertains to the art and science of experiment and demonstrated fact, and out of this accumulated wealth, correlate a harmonious adjustment, and then say to disturbed Nature: Get well! Brought



down to its ultimate analysis then, medical practice resolves itself into one, simple but fundamental fact: co-operating with nature and her laws.

In the practice of medicine the physician is prone to get into ruts. He develops fads and follows them to his undoing. He adopts the stereotyped methods of ambitious writers, copying their faults as well as their excellencies. Instead of thinking for himself he buys the goods already canned. He is too busy practicing medicine, and hence, has no time to study it. In this mad rush to get ahead and garner the golden ducats, let us not debase our noble calling to a mere commercialism. When failure comes—as it will—and man has exhausted his resources, he might, for self protection and satisfaction, ascribe his failure to that supernatural creature of universal reprobation—the Devil.

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## BUREAU OF SANITARY SCIENCE

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E. G. WHINNA, M. D., Chairman

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### THE PHYSICIAN'S DUTY TO SOCIETY.

BY

FRANKLIN F. MASSEY, M. D., WALTERS PARK, PA.

EVERY man, individually, has responsibility dependent upon opportunity, and opportunity dependent upon ourselves—hence personal responsibility. Thus a laborer has not the responsibility that a school teacher has. Man has not only a responsibility to his own family but also to society, and sometimes, the writer believes that some men have a greater responsibility to society than to the home, providing they are fitted for their public duties.

Since the time of historic Adam we have had a problem that has been combatted more or less successfully or unsuccessfully as the case may be, but which, nevertheless should be fought as hard or harder to-day. To-day we have more enlightenment upon many lines, but there seems to be a proportionate lack of earnest consideration in a personal way of the social evil. It

is the idea of this paper not to distort facts, not to flaunt fancies, but to try to impress upon the medical fraternity the truth that there is a personal responsibility facing them, and upon the homœopaths that we should take the lead. Too often the homœopath has let the older school of medicine take the lead in public thought and we to follow. Neither is it the intention in this article to discuss in detail the treatment of the social evil, but to call forth an earnest desire on the part of many of those following the thought of the article to do more than they have done up to the present time, in helping in the great cause for humanity. Much cannot be done to prevent an individual from becoming a profligate or a prostitute if they wish to follow that course, but much can be done to remove unnecessary ignorance. The social evil is dependent upon several factors:

1. Innate sexual desires.
2. Inherited tendencies.
3. Education—either good or evil.
4. Environment.
5. Habits and their formation.

#### INNATE SEXUAL DESIRES.

It would be useless to attempt to discuss the social evil in any respect without bearing in mind the innate sexual feeling that we are born with. Too frequently this fact is lost sight of, both because of ignorance and so-called modesty. It has astounded many when they have been brought to the realization of the fact that sexual feeling is apparent at a very early age, either with or without the knowledge of the person in particular. Sexual feeling and a perverted feeling at that, may exist and the person be ignorant of the truth that the feeling be a sexual one. As an example, I have, upon more than one examination of boys less than a year old, found that a decided erection of the penis takes place upon being handled. Also I know of more than one case where there has been masturbation indulged in and without any particular knowledge as to the real nature of the act, of course these latter cases being older children. These are not isolated cases, but can be seen as frequently as one desires if he or she will but observe. These statements may seem astounding, but are made to impress the truth upon the ones hearing or reading this paper, the fact

that there is an innocent sexual desire, or at least a feeling or instinct, of as great an intensity as the reflex act of pulling the hand away from a hot stove lid. Later on, at the age of, say, eight or ten, the feeling is more intense than the average parent imagines, and many physicians are not inclined to take much notice of the fact as the children are considered pure and innocent. It is really at this age that much damage has been done in many cases. Thoughts indelibly impressed upon the growing mind are made at this age. It is at this age that the child seeks for knowledge of all sorts, and, believe me, that it generally finds out in some way what it desires to know. Why not the right way in those matters of sex? Where does our duty as a physician lie? Parents cannot be supposed to know the full measure of danger that lies before their youngsters, without they be shown it. In the next few years, say from ten to fourteen years, of course many people realize something of the dangers, but even at this age there is a great laxity evidenced. Each mother thinks her little boy or girl just budding into adolescence is all right. Again, here the innate sexual desire is especially manifested in numerous ways only too well known to dwell upon at present. Thus it is hoped that it has been proven that there is an innate sexual feeling almost from birth to adolescence. Why not impart sufficient knowledge as the child grows, so that it may be able to combat that evil in-born tendency?

#### INHERITED TENDENCIES.

It is commonly recognized that inheritance plays a great part in our lives, but too little stress is laid upon these tendencies. Talking is not sufficient. In a former paper the writer has called attention to the fact of these tendencies and the manner in which they may be communicated in a physical way, and also called attention to the fact that although a man or woman may be reformed, the original sins of the parents can and frequently are visited upon the progeny—thus a good, pious man, who has really reformed and is living a good, clean life, may have born unto his wife a child who may exhibit all of the old tendencies of the parent, or to have other perversions. The fact that a man has overcome his sins does not exempt his children from manifesting them. Let us learn to realize that we have a duty before us to help in the formation of the characters



of the members of the coming generations, and that this duty is not just for the time being, but also for posterity.

#### EDUCATION.

To the mind of the writer, education has a great deal to do with the formation of character, and education backed by the proper stamina can be the means of overcoming even the strongest inherited tendencies. By education is not meant what is learned in the school room alone, but what is learned from all sources. Thus a child may be taught certain things, but unless taught how to make use of the knowledge, it is not real education. As an example: A boy may have the best training in the Sunday School, in the theory of what should be, but often gets his real education on the streets with his companions, and although he has had teaching of the best kind in the Church, on the streets he gets the practical education—there he learns how to smoke, chew, drink, gamble, swear, etc. If children were educated in a practical manner how to apply the good knowledge, as they are taught practically how to make use of evil knowledge, the world would be better. Education should not simply be directed to show that it is right to do this or that, not to learn the rules of anything alone, but to show why and how to overcome good or evil and to understand the reasons for the problems in the books or elsewhere. Do not teach the child that it is evil to do such and such a thing, but give it a practical way to substitute that which is better. Now, children are constantly being taught in a practical way what sex is and its various practices—they are being educated from almost infancy up. Any child of school age is not immune from a vulgar education no matter how much they may go to Sunday School or Church. Sex is tabooed by parents and teachers and ministers as well; but mark my word, the children are getting educated without their help. It is the physician's duty to explain to parents the great necessity of a parental teaching in matters of sex. Thus the writer insists upon a widespread effort to systematically teach parents how to educate their young in matters pertaining to sex. Teach the parents how to handle the subject properly and to make confidants of their children. Within one week the author has known of three fine families to have acknowledged the fact that their children were not as innocent as they appeared to be.

The cases were: (1) A little girl of  $4\frac{1}{2}$  years was enticed into an outhouse by an older boy; (2) a girl not ten years was insulted by a boy but never told her mother. The matter leaked out in another way, although the little girl remained pure. She was afraid to tell the parent. (3) A girl of under twelve who had continuous knowledge of a man in the vicinity. None of these children were bad children, and all went to Sunday School and all were brought up in good surroundings. These children were getting their education, real education, lessons that they will never forget. In the school room, the dancing academy, theaters, shows, parks and streets the children are getting their education as well as in the homes. Early training will help here where nothing else will. Every normal child will sometime frankly ask the parent a frank question, but almost as frequently the answers are veiled and unsatisfactory to the child. Be frank! We as doctors should impress this upon parents and teachers.

#### ENVIRONMENT.

Children are natural imitators, and environment plays a great part in the development of the tendencies and the application of the knowledge obtained. To-day little attention is paid to the association of children and we forget that in all Life's great or little journey "we are a part of all that we have met." Every person, good or bad makes some conscious or unconscious impression upon us, and we are appropriating generally unconsciously and their lives or the expression of their lives becomes a part of our own. Hence, a great necessity for proper environment. One good way is for the elders to make the children want them—to make the child feel natural while the elders are around—not self-conscious. That very fact will teach children not to want to steal away by themselves. The social conditions of to-day are certainly weakening to good morals from the high colleges to the poorest kindergarten. We as physicians could and should have some say in helping the environments.

#### HABITS.

The nervous system of man is so made up that when the same impression or sensations is made more than once that

the result is more and more mechanical, so to speak, and is more easily duplicated—thus, if a child is allowed to cry when not really suffering, as it grows older it becomes a “cry-baby,” and later a spoiled child, and, lastly, as a rule, a hopeless neurasthenic. A word repeated, time and again, is learned by the child. A picture makes its impression, an act is not overlooked. Sometimes an impression may cause a sensation which can be duplicated in another way and, believe me, when I state that a child may be depended upon to find out that other way.

The sexual vices are matters of habit to a great extent and it is to avoid the forming of the habits that we should direct our attention. Endeavor in every way to forestall the formation of the habit and you have cured the ill before it is begun. Teach the parents that as soon as a boy or girl avoids others, to appreciate the grave meaning, also that when one particular boy or girl wishes to be with one other particular boy or girl that there is great danger. Remember that all the blame should not be on the boys, for girls lead the boys astray as often as the boys do the girls. In teaching physiology more enlightenment should be given, but it is a question with the author how much should be in the school room and how much from the parents or other persons personally interested in the particular child. It seems that the subject is such a delicate one that it can only be safely handled in a confidential manner with each and every child, but that there should be a widespread enlightenment of teachers, parents and ministers.

In conclusion, let me issue a call to the medical fraternity to lend moral aid to the committee on social evils so that they may impress upon doctors, nurses, teachers, ministers, etc., the need of disseminated knowledge. This, gentlemen and ladies, is the duty of the physician to society.

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**SCHOOL MEDICAL INSPECTION OF PHILADELPHIA.**

BY

WALTER S. CORNELL, M. D., PHILADELPHIA.

Director of Medical Inspection of Public Schools of Philadelphia.

THE history of medical inspection of school children is one of the results of the increased interest taken by the community at large in health matters and is indeed one of the most prominent departments in preventive medicine. Its growth has been remarkable, starting in the United States in New York City only nine years ago and now existing in numerous cities with comprehensive state-wide organizations in New Jersey, Massachusetts and Vermont.

The necessity of brevity in a paper which is to be read forces the omission of extended consideration of the influence of practical school hygiene, medical inspection and personal hygiene, upon the practice of medicine viewed from the standpoint of the individual physician. This is, however, a most important subject which might well consume the entire time of the speaker. At this time, however, our consideration will be given entirely to the work of medical inspection as conducted in Philadelphia with the endeavor to show the scope of our activities and the measure of success which has attended upon them.

Medical inspection of school children at the present time is conducted under the authority of the Act of 1911, known as the School Code, which provided for a complete reorganizing of the school system of the state, and among other comprehensive innovations the medical inspection of every school child in the commonwealth. Under this Act school districts are divided into four classes, corresponding to the four classes of municipalities. In school districts of the first class the health authorities may conduct the school inspection, the expense, however, being met by the school authorities. In school districts of the third class and fourth class an unfortunate provision exists that the school boards may, if they so desire, suspend the work of medical inspection for a year's time.

The city of Philadelphia possesses at the present time a system of school medical inspection which is probably equal or superior to that in any American city. It is under the immedi-

ate direction of a chief with five supervising inspectors and fifty-six assistant inspectors. This number will doubtless soon be increased to sixty or sixty-five, as the present corps is not able to meet the demands upon it. The medical inspectors are assisted by twenty-two school nurses, supervised by a chief nurse and assistant chief nurse. The annual expense to the city, or strictly speaking, to the Board of Education, is \$65,000, or \$.30 per school child per annum. With this force the schools are regularly visited for the purpose of detecting contagious diseases and the examination of children suspected by the teachers to be suffering from physical defects, and in addition every school child of the whole 180,000 school children in the city is given a complete physical examination each year, such examination including the inspection of the eyesight, hearing, nose and throat, teeth, nutrition, heart and skin. The School Code also provides for the sanitary inspection of school buildings by the medical inspectors and twice each year a systematic examination of every building is made and reports submitted to the chief medical inspector. Numerous special reports from the inspectors are made when the occasion warrants.

In addition to the detection of contagious diseases, the physical examination of the children and the sanitary inspection of buildings, which are specifically provided for by law, the work in Philadelphia also includes special physical examinations of children at the request of the Bureau of Compulsory Education to determine whether or not these children should be excluded from school on account of ill health as the parents request; physical examinations of applicants for the position of school janitor; examination of mentally deficient children at a clinic conducted weekly; and the medical supervision of school children in the open air and other special classes.

Some of the figures taken from the report on the work done during the last six months may be interesting as showing the extent to which children of school age suffer from the principal physical defects. There were those of defects of the teeth 29,389; of the nose and throat 19,770; eye 15,403; orthopedic (mostly stoop shoulders and flat chest) 1,265; anemia and poor nutrition 1,578; miscellaneous diseases of the skin 9,128; defects of the ear 1,331; nervous disorders 459; heart diseases 177; feeble mindedness 80, and miscellaneous 4,087, making a total of 82,667.

The number of exclusions from school on account of reportable contagious diseases is also interesting, because the school is the great focus for the disseminating of the contagious diseases, and also because it was on this account that the medical inspection of schools was first instituted.

The school inspectors report not only cases seen personally but also reported to them second-hand by responsible parties. Such responsible parties comprise the school teachers and parents. The cases seen by the inspectors and those reported by a second party are recorded separately as the inspectors, naturally, are not held responsible for cases they are reporting at second hand, simply to help the Health Bureau in its work.

Between January and June, 1,427 cases of contagious diseases were reported by the inspectors, 1,096 of these being actually found in the schools. The great majority, fortunately, were mumps and chicken pox. These two comprised 800 cases. However, 72 cases of scarlet fever, 15 doubtful cases of scarlet fever and 77 cases of diphtheria were discovered.

The minor contagious diseases, such as pediculosis, ringworm, scabies, epidemics of acute conjunctivitis and acute sore throat are found in considerable numbers in the schools. Pediculosis 758, ringworm of the skin 204, ringworm of the scalp 52 cases, scabies 114, acute conjunctivitis, 164 and acute sore throat 708 cases, are recorded in the reports of the last five months. Total, 2,109 cases.

The number of children infested with pediculosis really runs up into thousands, but the majority of such children are found by the school nurses and their heads cleaned at home, without the necessity of calling the inspector's attention to the matter.

Our modern knowledge that diphtheria bacilli are often carried in the throats of children not suffering from sore throat or other symptoms of infection has commended the policy of taking cultures from the throats of children who have sat at school desks close by the desks of children actually suffering from diphtheria. In the last five months already mentioned, 542 cultures were taken with 21 resulting positive cultures. These children were promptly sent home, their parents notified of the condition and were not allowed in school until further cultures by the family physician showed negative cultures.

The disinfection of school buildings is performed at an average rate of six or seven weekly. Our general rule is to close and disinfect the school at once if a case of diphtheria or scar-



let fever is actually found in the school. Disinfections are postponed until Saturdays if there are epidemics of the less contagious diseases, such as mumps, chicken pox or measles, or if two or three cases of scarlet fever or diphtheria have occurred in the families of children attending the school. It must be remembered that the disinfection of the school house on Saturday costs about five dollars, while the disinfection of a school on a week day necessitates the closing of the whole plant with a consequent cost (estimating each child at 15 cents per day or seven cents per half day) of at least fifty dollars to the educational authorities. To close one of the large schools recently erected, accommodating 1,600 children would entail a loss of about one hundred and fifty dollars on each occasion.

The sanitary condition of the school buildings is given prominent place in the work of medical inspection, since it is provided for by the law. The 300 school buildings of Philadelphia furnished in five months 117 complaints forwarded by the school inspectors, of which 60 were on account of the toilets, 14 on account of illumination, 9 on account of ventilation, 9 on account of yard paving, 8 on account of water supply and the other miscellaneous.

The School Code, recently passed, provides that no person shall be employed as a school janitor who is suffering from tuberculosis or other infectious disease, and by arrangement with the Board of Education, the Bureau of Health has undertaken to examine the applicants for the position of school janitor, certifying that they are free from tuberculosis and also that they are physically able to perform the duties devolving upon them. This will naturally bring about a much higher standard among the janitors and other employes of the department of buildings.

The Bureau of Compulsory Education has requested that those school children whose parents request their excuse from school attendance on account of poor health shall be investigated and an accurate report made to the chief compulsory attendance officer. In the great majority of the 185 absentee children seen last spring, the request of the parent for temporary withdrawal of the child was justified, but occasionally a case was found in which the underlying motive was to send the children to work somewhere,—particularly to work with some relative who will pay the parent for the child's labor, but will not employ the child on a regular formal basis.

The increased interest of educators and social workers and physicians in the subject of feeble mindedness, the lesser grades of mental deficiency, has caused a closer scrutiny of those children who are not able to do ordinary school work. Many of these children have proven to be feeble minded, but many others have simply been retarded by reason of adenoids, poor nutrition and bad home surroundings. For the purpose of giving a special examination with expert opinion on cases supposed to be feeble minded, a weekly clinic is held at the Bureau of Compulsory Education, 1522 Cherry street. Here last spring 103 cases were examined, of which 54 were judged to be feeble minded. Some of those were helped to admission in Spring City and others are now on the waiting list.

A few words about the general viewpoint of those who are directing the medical inspection work in Philadelphia and their plans towards the improvement of the health of the whole mass of children.

The department employs, at the present time, fifty-six inspectors, five supervising inspectors, a head nurse, and twenty-three assistant nurses to prosecute the work of school inspection. The duty of the physicians is to detect children suffering from contagious diseases and to exclude them from school. Also to detect noteworthy physical defects which, by their existence, are injuring the children. The inspectors do not treat the children medically because they have no authority from the parent to do so; nor would it be practical because of the lack of equipment, and because of misunderstandings with other physicians, and because ten times the number of inspectors would be required. At times misunderstandings have occurred as to the purpose of the physicians carrying on the work. Several years ago when medical inspection was instituted a few physicians believed that the school inspectors would endeavor to make private practice out of their official work. Such a suspicion has proved to be absolutely unfounded, experience having shown that the existence of a salaried position makes the carrying on of a private practice a rather difficult matter. On the other hand, it has been remarked that the medical inspectors were engaged principally in sending patients to their fellow physicians in private practice, a statement which distorts the facts in such manner, as would the statement that feeding a hungry child makes money for the baker or the suggestion that sending a child to school is done for the purpose

of providing work for the teacher. In other words, we are simply endeavoring to get needed things properly done according to the accepted manner of doing them.

It has also been remarked that a great many children sent by the medical inspectors resort to the hospital dispensaries for free treatment. This is true enough, but it should be remembered that many of these cases are worthy charity cases and that the inspectors never recommend primarily a dispensary to any one, leaving the economic and financial side absolutely with the parents.

There is no doubt that dispensary abuse does exist throughout the city, both in the case of children and of adults, but the fault lies with the management of the hospitals, and with the dispensary physicians who are willing to treat bogus charity cases without protest. The dispensary matter has nothing to do with school inspection whatever.

It is the earnest aim of this department that not only are the physical defects and contagious diseases properly handled but that the broader subject of personal hygiene be brought to the minds of the children through the health matters now forced upon them. There is no doubt that the practical knowledge gained by the children from notices sent home, concerning headaches from eye-strain, indigestion from decayed teeth, deafness from adenoids, and squint from eye-strain, has made the children much wiser in health matters than they were a few years ago and indirectly the children are educating their parents. We hope in the near future to broaden the work with a close co-operation with the Department of Physical Education so that the stoop shouldered children will be specially selected for corrective exercises. We hope also to correlate with those forces social activities in the schools so that whenever parents' meetings are held at the social centers instructive talks may be given to the parents as well as to the children.

The results obtained from medical inspection have so far been gratifying, but not as good as they might be. Quoting most briefly, 31 per cent. of the eye-strain cases have secured glasses, 30 per cent. of the nose and throat cases have been treated, 66 per cent. of the ear cases have been treated, 30 per cent. of the cases of decayed teeth, 46 per cent. of malnutrition cases, 34 per cent. of the orthopedic defects. These figures vary considerably according to the social status of the children and



also according to whether or not a school nurse assists the doctor by visiting the parents and personally urging the correction of defects.

The plans for future medical inspection work embrace activities even more comprehensive than those already prosecuted. First will be attempted the measurement by practical standards of the degree of illumination and ventilation of the different buildings. At the present time it is well known that poor ventilation is an ally of poor nutrition and tuberculosis, and that poor illumination entails a serious strain upon the eyes, but so long as we lack concrete terms of measurement by which these conditions can be accurately measured so long are we helpless to call attention to them properly and to effect their betterment. In the past the school authorities have endeavored to co-operate with us in the correction of such sanitary complaints as have been brought to their notice, and this same spirit of co-operation will doubtless be shown if we are able to present the matter of poor illumination and poor ventilation intelligently.

One of the most precious of our possessions is good teeth, and our instruction of children along this line should be eminently practical. We should be sure that every child owns a tooth brush and knows how to use it. At the present time we need some philanthropist to bring this idea into the home of every one of the 180,000 school children of Philadelphia.

Until drinking water fountains are invented which will at the same time keep clean and not waste water, it is also a desirable thing that every child should possess his own drinking cup. Here, again is an opportunity for a philanthropist, or some mercantile firm wishing to do some benevolent advertising. The very idea of possession of drinking cups and tooth brushes tends to make the child think of individual cleanliness and to produce that dislike of common towels, common cups, which is essential to a cleanly life.

We also need badly some sort of sanitarium to which Philadelphia school children, suffering from poor nutrition, can be sent for a month or more. At the present time we have only charities which are active in the summer. A good sized farm would be a fine acquisition to the city plant or a fine private charity. The movement to procure the old Lazaretto property at Essington, known as the "Orchard," for this purpose should not be allowed to drag. The buildings here would accommo-

date two hundred children and there are some eight acres of ground right on the river bank, with both train and trolley service nearby.

The fact that social work in connection with the school system has come into existence in various parts of the city brings also the thought that the various parents-teachers associations, school alumnae associations, and social centers may include in their programs instruction to parents on matters of health. Nothing more valuable and probably nothing more welcome could be offered and it would cost but little to prepare a series of pamphlets or tracts to be distributed and studied at such meetings.

The success which has attended the Boy Scouts movement and the growing realization of the public that health is the cheapest and yet the dearest thing in the world and that mental efficiency depends largely upon physical efficiency, brings to mind the idea of the establishment of a health league or health association among the school children, the members to be composed of these children who obey, the recommendations of the medical inspectors, physical instructors, and the directions of right living marked in a manual prepared for children of different ages. Such membership, if certified by an appropriate emblem, would possibly prove wonderfully popular. These results would be of inestimable value.

In conclusion, we would say that it is our hope that the matter of health of children will receive more and more attention from the school authorities generally. Doubtless it will soon be taught in our normal schools as a credited and essential subject. It will be only a step from this to the official recognition of the child's physical efficiency. Then will come the statement to the parent by the educational authorities that the child's health index is of a certain grade just as is his standing in geography, spelling and arithmetic. With the use of accurate measuring standards of health, even though these be empirical, will come the realization by the parents that their child is not only defective physically, but that his defectiveness is calculated by the school authorities. This is really the step needed to make all parents realize that health has a definite value in the eyes of those officially entrusted with the matter. It would solve many difficulties which are now attacked less successfully through more expensive agencies.

## DISCUSSION.

DR. JOHNSON: In regard to drinking cups, I would say that the use of a proper drinking fountain largely does away with the necessity for such cups.

DR. CLARKE: I have been very much interested in this paper on School Inspection, for we are just starting on this work in Scranton. May I ask what compensation is paid in Philadelphia?

DR. CORNELL: The salary is three thousand dollars. There are fifty-six assistants who receive six hundred dollars each, and only work two hundred days, three hours a day. The compensation is one dollar an hour.

DR. CLARKE: Our inspectors in Scranton are not well paid. I was appointed one of the inspectors and was supposed to examine five children in an hour. The compensation was to be two hundred dollars a year, or five cents for each child inspected. I have talked with different teachers and find that one reason for deformed children in schools is that the desks are not suited to so many pupils, and, as a result, they sit in abnormal positions. We are trying to provide hygienic lunches and to encourage better hygiene among the pupils in every way.

DR. J. A. FISCHER, Philadelphia: This paper is a revelation to me of the progress that has been made in Philadelphia. I recall when all of this work was done by volunteers and they received no compensation. I do not think we support these movements as we ought, as they undoubtedly tend to improve the health of the children.

DR. E. A. GLENN: I would like to ask whether the doctor notifies the parents that the child needs attention.

DR. CORNELL: The school code provides that the inspectors notify the teacher, who, in turn, notifies the parents. It is easy to see in a small town, where everybody knows each other that there may be three physicians and the idea of the law is that the physician who has been made inspector should keep himself in the back ground and not endeavor to get all of the practice in the town. The laws bearing on this subject can be obtained from Nathan Schaeffer, Superintendent of State School Inspection.



## EDITORIAL

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### A DISCUSSION OF THE PRINCIPLES OF HOMŒOPATHY.

WHILE we are endeavoring in the experimental laboratory and at the bedside to work out the practical application of homœopathic methods, it is also important for us to give consideration from time to time to the principles and laws that underlie these methods. It is but natural that a variety of views should exist as to the manner in which homœopathic remedies operate in restoring the sick to health, and the ultimate truth regarding this matter will probably be arrived at as the result of the combined efforts of many minds.

For the purpose of obtaining a more or less general expression of opinion on these matters from those who are interested in homœopathic philosophy, Dr. Jos. C. Guernsey has submitted a theory of the *modus operandi* of the homœopathic remedy to a number of homœopathic practitioners with the request that they express their views regarding it.

In the present issue of the *HAHNEMANNIAN* will be found communications on the subject from Dr. James H. McClelland of Pittsburgh, Dr. Edward Cranch of Erie, and Dr. Royal S. Copeland of New York. The views of other authorities will be published in our February issue, and it is the hope of the editor that these articles may prove a stimulus to other physicians who have given thought to this matter, to write up their views for the benefit of the profession and to forward them to the editor of the *HAHNEMANNIAN* for publication.

G. H. W.

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### THE ROLE OF DISEASES OF THE ABDOMINAL ORGANS, OTHER THAN STOMACH, IN THE PRODUCTION OF GASTRIC DYSPEPSIA.

DYSPEPSIA has been said to be a characteristic American disease, and certain it is that every medical practitioner is called upon daily to prescribe for patients suffering from some form of gastric disturbance. For many years it has been the custom to consider the vast majority of such cases as being the result of purely functional disturbances and many of these patients go year after year complaining of a long list of abnormal

sensations for which they have consulted physician after physician with little or no relief.

A more careful study of these conditions during recent years by gastro-enterologists and abdominal surgeons, has shown that the percentage of these cases of functional origin is much smaller than was formerly supposed, and that many of them are due to organic alterations in the stomach itself or in some of the other abdominal viscera. Duodenal ulcer, chronic appendicitis and chronic infection of the gall bladder are, in particular, conditions that are frequently the unrecognized cause of gastric dyspepsia.

Duodenal ulcer, until recently a supposedly rare disease, is, as a matter of fact, a comparatively common malady. Its most characteristic symptom is pain occurring three or four hours after meals and relieved by food. Moynham designates this pain as "hunger pain," and considers it pathognomonic of this condition. We do not believe that this view is entirely in accord with clinical experience, but the fact remains that typical "hunger pain" should always raise in the mind of the physician a strong suspicion of the presence of gastric or duodenal ulcer. If this symptom occur in periodic attacks, lasting two or three weeks or more, followed by a period of apparent health, and, particularly, if it is associated with a mild jaundice, due to swelling of the papilla of Vater, the diagnosis of duodenal ulcer becomes almost certain. The presence of occult blood in the feces at intermittent periods would strongly confirm such an opinion.

Chronic appendicitis is a factor in the production of gastric symptoms in not a few cases of chronic gastric dyspepsia and one that is not always easily recognized. Where we have distinct pain about the appendix associated with tenderness on deep pressure, the diagnosis is usually easily made; but our greatest difficulties arise in those cases of adhesions and kinking of the appendix in which an ordinary physical examination may fail to give any definite signs. It has been noted that a careful record of the temperature range in patients suffering with chronic appendicitis will usually reveal a slight rise of temperature above the normal some time during the twenty-four hours. A slight increase in the leucocyte count with a relative increase in the neutrophiles is also observed at more or less frequent periods in this condition. Constipation, a feeling of discomfort in the right iliac fossa after exercise, and

the production of pain by the sharp flexion of the right hip, are occasionally concomitant conditions that may aid in the diagnosis.

It is not easy to explain why a very mild chronic inflammation of the appendix may give rise to marked gastric disturbance, but the prompt and permanent relief that has followed the removal of the appendix in innumerable cases has proved conclusively that the appendix is a positive factor in the production of many of these cases.

Chronic inflammation of the gall bladder and of the gall ducts can often be demonstrated in cases of chronic dyspepsia by a careful examination. As a rule these patients suffer more or less from so-called bilious attacks and acid dyspepsia. A gastric analysis will frequently reveal an excess of hydrochloric acid in the otherwise normal stomach contents. There may or may not be a tendency to slight jaundice at times and pressure at the costal margin at the tenth rib or at a point midway between the margin of the tenth rib and the umbilicus will elicit some tenderness. There may or may not be a history of attacks of gall-stones or of some preceding inflammation of the intestines, especially typhoid fever, that is capable of setting up a secondary inflammation of the gall bladder.

It must, of course, be admitted that some cases of chronic dyspepsia are of functional origin, but no case of this nature should be permitted to go on month after month without a complete and painstaking examination being made to exclude organic disease of the stomach or of some other abdominal organ.

G. H. W.

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#### SOME OF THE DANGERS OF SALVARSAN.

PERHAPS no medicinal agent that has been brought before the attention of the profession for the past decade has excited such universal interest as salvarsan in the treatment of syphilis.

It is small wonder that both the medical profession and the public received with open arms this product which one of the most noted scientific investigators in the world had announced would eliminate one of the most loathesome diseases that has affected the human race in one or two doses.

During the past two years several hundred thousand injections of this substance have been used and experience has shown that while the drug is of definite value in the treatment



of syphilis, it has well-defined contra-indications, limitations and dangers. To compile a list of all the fatal accidents that have been published during the last two years would be an arduous task, and, yet, it is probable that only a small percentage of such cases have been reported in medical literature. Leredde and Kuenemann, more than a year ago reported a series of fifty-five deaths following the intravenous injection of salvarsan and twenty-five of these the authors attribute directly to the drug; seven were doubtful and twenty-three were attributed to other factors.

Gottheil reports a very instructive case in which an otherwise healthy woman of forty years of age was injected for a small tertiary ulcer on the back. She died three weeks later, and an autopsy showed an acute inflammation of the kidneys accompanied by acute degeneration of the heart muscle. The pathologist stated this was undoubtedly the result of arsenical poisoning. It is, of course, admitted that not all deaths following the injection of salvarsan can be attributed to the use of this substance. But even the most enthusiastic advocates of its use have been compelled to admit that a therapeutic agent, the administration of which has been so frequently followed by serious and even fatal results, cannot be regarded as harmless, and that great caution must be employed in recommending its general use.

Aside from the fatal accidents that have occurred from the use of salvarsan, various authorities have reported the occurrence of nephritis, convulsions, bi-lateral ocular paralysis, epileptic attacks, venous thrombosis, etc., all of which conditions are probably the result of the poisonous effects of the arsenic. These complications are especially likely to occur in patients who are suffering from chronic or latent diseases of the nervous system or of the internal organs, and it is generally accepted that disease of the kidneys, heart and blood vessels or of the ophthalmic or other nerves of special sense, are contra-indications for its use if the abnormality is not of syphilitic origin. Late syphilis of the nervous system does not necessarily contra-indicate the use of the drug, but the opinion of most authorities is that it is useless to administer it in such conditions.

It is interesting to observe that even the advocates of salvarsan now advise that a course of treatment by mercury should follow the injection of "606," thus indicating their un-

willingness to rely solely upon the therapeutic properties of the remedy itself. It would seem, therefore, that there is very little likelihood of salvarsan replacing former methods of treatment in routine medical practice, and that it is only in obstinate cases or in those in which rapid results are desirable that the drug should be employed. The popular method of employing the drug, namely, the intravenous injection, is also not unattended with risk, and the custom of giving such injections in office treatment must be emphatically condemned. If such an agent be used by the intravenous method the patient should be kept in bed and every safeguard that antiseptic technique affords should be employed.

G. H. W.

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INJECTION OF STERILIZED AIR INTO THE VITREOUS BODY FOR DETACHED RETINA.—The author gives his results in seven cases, most of whom were myopes of high degree. His results do not warrant imitation, as the effects produced were of the most temporary character. In one case only, and that a nonmyopic traumatic case, was the retina still attached at the end of four months. As to the technique, Rohmer uses a glass syringe with an iridoplatinum needle; the needle is brought to a glow in a spirit lamp, and the air aspirated through the needle, thus insuring its sterility. Rohmer advises that the needle be introduced through the sclera at a point opposite the detachment, and then shoved through the vitreous far enough to lacerate the retina overlying the fluid deposit. The subretinal effusion is then tapped by thrusting a Graefe knife into it and allowing it to escape. Under a pressure varying from little to 300 grams about a cubic centimeter of air is injected in the vitreous. The resultant pain is very slight and the air disappears in twenty-four hours. The injections may be repeated without danger, as long as the pressure and time of injection (three to six seconds) are not excessive.—*Dr. Nancy Rohmer.—Archives d' Ophthalmologie.*

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OCULAR LEPROSY.—The writer says that leprosy is on the increase in Cuba, but its ravages have not been alarming. Ocular complications are common and usually progressive. Out of 250 cases seen by the writer, 150 had some eye trouble, and more than 30 had partial or total loss of vision. The eye complications are usually secondary. Eyebrows and eyelashes are absent in nearly every case, conjunctivitis is common, and frequently neurosis and ulceration of the palpebral and orbital tissue follow. Keratitis is frequent and is usually an extension through the corneo-scleral junction. It spreads slowly until the whole of the cornea is involved. This inflammation is very painful, and the pain seems to be the most severe that the patient has to bear in this disease. The cornea becomes opaque and occasionally abscesses form and perforations result. The leucomata in these cases becomes very white and the cornea thin. The iris becomes inflamed by extension from the uveal tract, the retina, choroid and optic nerve rarely are affected, and the lens may be reached by extension late in the course of the disease.—*Dr. Francisco M. Fernandez, Havana. Ophthalmology.*

## GLEANINGS

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HOW TO BECOME A NEURASTHENIC.—Eat no breakfast.

Indulge in but one meal daily; at any rate not more than two. Eat no meat. Eat freak cereals, vegetables, nuts and fruit.

Masticate every morsel two hundred and sixty-eight times—two hundred and sixty-seven times won't do.

Take a cold bath every morning.

Take a laxative every day whether you need it or not. Better still, a cathartic. Take enemas frequently.

Be massaged daily.

Read the health magazines daily.

Read all the books on how to gain self-control and on psychotherapy.

Concentrate the mind upon the digestion and upon all articles of diet.

Upon every possible occasion discuss your imaginary troubles with your friends and coerce your wife into catering to every dietetic whim that you can formulate.

Buy a lot of apparatus for indoor exercise and roll a cannon ball around the abdomen every day along the course of the colon.

Be treated by someone who uses only the static machine in his practice for all cases—one of those lads who can reduce an enlarged prostate with vacuum electrodes.

If all else fails, try Christian Science.—*Critic and Guide.*

POISONING BY ARSENIC IN CARPETS.—A report by Professor Kuttner tends to show that, though the use of arsenic as a carpet dye is illegal in Germany, poisoning from this source is not rare. The victims complained of chronic diarrhœa, which was intractable at home but speedily disappeared on change of residence. When the patients returned home the diarrhœa recurred, in spite of every dietetic precaution. The possibility that the diarrhœa was of nervous origin was at first entertained, for there is such a form of diarrhœa which can be cured by removing the patient from home surroundings. But the patients in question exhibited no signs of neurasthenia or hysteria. One of them, a man aged thirty-two, complained of abdominal pain, and the passage every day of six to ten watery motions. Those contained unaltered bile pigments, muscle fibres, starch, fat, and mucus. A blood count showed secondary anæmia. After treatment in hospital for sixteen days he was discharged in perfect health, but a relapse occurred within a few days of his return home. Another stay of ten days in hospital was followed by recovery succeeded again by a relapse on the patient's return home. Arsenic was sought for, and found in the bedroom carpet. A little later a second patient developed chronic diarrhœa, which ceased only when he changed his quarters. An analysis of his bedroom carpet showed large quantities of arsenic. His wife suffered from headaches and lassitude, but not from in-



testinal symptoms. A third patient developed severe diarrhœa at her first confinement, and for the following year and a half suffered from chronic diarrhœa, which reduced her to a state of profound emaciation and anæmia. Here, again, relief was obtained only by change of residence. Arsenic was found in the urine and also in her bedroom carpet. While the patient had slept with her windows open she had been quite well, and the diarrhœa occurred when, during the puerperium, they were kept shut. It is probable, therefore, that the arsenic reached the system by inhalation. In two women, aged 52 and 56 years, respectively, who suffered from anorexia, lassitude and a tendency to diarrhœa, the blood counts are said to have been characteristic of pernicious anæmia. The bedroom carpets contained arsenic, as did also the urine in one case. Regrettably enough, the urine was examined for arsenic in only two of these five cases. The absence of arsenic from the urine does not exclude arsenical poisoning; nor, on the other hand, does the demonstration of arsenic in a bedroom carpet establish a connection between it and obscure toxic symptoms. But there is little doubt as to the connection in the cases recorded, for the reasons given above. As arsenic is also employed in the manufacture of cheap linoleum, its presence in bedrooms must be common, and it is consequently advisable to suspect its influence in all cases of obscure anæmia and intestinal catarrh.—*British Medical Journal*.

CRYPTOGENIC SYPHILIS.—Lane, in *The London Medical Lancet*, alludes to two cases described by Jullien. Two medical men, a surgeon and his assistant, operated on a woman of thirty-two for a tubercular swelling of the sternum. After excision and scraping they proceeded to sew up the wound. The needle, however, was a blunt one, and the surgeon in trying to force it through the skin wounded himself deeply on the end of the right index finger by a cut which bled somewhat freely. Subsequently the assistant met with a similar mishap, and wounded himself on the same finger. In both instances the puncture was healed in three or four days. On dressing the patient's wound for the first time eight days later they observed a slight ulceration with red edges at the seat of each suture, which suggested the possibility of syphilis to them, and on the following day a general macular eruption manifested itself on the patient. On examining her genital organs a healing chancre was discovered on a level with the fourchette and also some enlarged inguinal glands.

Twenty-six days after the inoculation the surgeon had a feverish attack with a temperature of 103 degrees F., shivering and sickness, and had to remain in bed for a day. At the same time the site of the needle wound became sensitive and the end of the finger became swollen, and a slight ulcer appeared; this was followed on the thirtieth day by a macular eruption, and a week later by mucous patches on the scrotum and tongue; subsequently the syphilis pursued its ordinary course without any severe symptoms. The assistant had no sign of infection before the thirtieth day, when he also had an attack of fever, and though no changes appeared at the seat of inoculation a macular syphilide showed itself on the thirty-third day.

THE TREATMENT OF THE THREE GREAT SYMPTOMS OF ULCER OF THE STOMACH.—Loeper, Paris. The three main symptoms of gastric ulcer are hem-

orrhage, vomiting and pain. The treatment of hemorrhage is the most important part of the treatment of gastric ulcer. The essentials of this treatment are: complete rest in bed, ice per os or in local application, hot rectal injections and drugs. In subacute hemorrhages perchloride of iron or bismuth salts may be useful; but adrenalin chloride of calcium and gelatin are certainly better, and may be given per os with excellent results in all cases of hemorrhage. Ergotin, ergotinin or adrenalin hydrochloride may be given in hypodermic injections; their action is rapid but temporary and often there is a recurrence of hemorrhage soon after their use. Horse serum or normal saline solution are also useful, the former in hemorrhages of long duration where there are distinct modifications of the blood, the latter in profuse or prolonged hemorrhages to make up for the loss of fluid of the system. Gelatin solution may also be tried hypodermically, but it seems to be less used nowadays than some years ago. The food must be as bland as possible, and Prof. Loeper is distinctly in favor of the old fashioned milk diet for at least four weeks; however, when the hemorrhage cannot be checked rectal feeding must be tried. Vomiting must be checked by external means and cold applications, (ice, ether, methyl chloride, etc.) since the analgesic mixtures taken per os are likely to cause vomiting. Alkaline powders are very often of great value and generally well borne. For hypodermic injections a mixture of atropin and morphia gives excellent results in most cases. Nitrate of silver may also be of use, but it is likely to give an extra stimulus to the mucous membrane of stomach, which is already so irritable.—*Progress Medical.*

THE ROLE OF EYE-STRAIN IN GENERAL PRACTICE.—Cobbedick discusses the association of eye-strain with certain nervous diseases. The types of eye-strain headaches are frontal and supra-orbital, frontal and occipital combined, occipital alone, and bi-temporal. The vertical headache of the neurasthenic and the intense diffuse headache of migraine are distinct from typical eye-strain headaches and sustain no close relation to such strain. Eye-strain may be an exciting cause of migraine but there is no constant connection. The frequency of the attacks and sometimes their severity may be diminished by treatment of a refractive or muscular balance error, while in a small percentage of cases cure results. The dull headaches which migraine patients are subject to between attacks can always be cured by appropriate lenses. Epilepsy must be cured or relieved by the use of lenses. One can quite understand a motor cortex in such a borderland state of instability as to break down with any peripheral nervous irritation, such as an eye-strain, and when eye-strain is the only source of irritation one might expect relief from its correction. Even a few successes make it well worth while to investigate the refraction and muscular balance of all cases of the functional neuroses, for if cure is only occasional some measure of relief is quite common.

There is a class of cases whose symptoms consist of extreme nervous irritability and change of temper, headaches, and occasionally vertigo, without other symptoms of neurasthenia. This symptom-complex is usually ascribed to functional liver derangement. These cases can be cured by attention to the refractive errors and not by purges. True neurasthenics nearly always present some symptoms of eye-strain. Accommodation is apt to be an effort for them, inasmuch as the muscles of conver-

gence participate in the general condition of myasthenia. The vertical headache, the peculiar sensations of oppression, pulsation and band-like constrictions of the head, have no relation to eye-strain. The other types of headaches, if present, can be relieved by lenses. Eye-strain can hardly be regarded as the cause of *well-marked* neurasthenia though it may operate along with other factors. It may be the main factor in slight cases of neurasthenia in which there is a good family history. These cases are cured by wearing lenses. Neurasthenia is practically always relieved by the correction of existing refractive errors. The same thing applies to such a serious class of cases as the definite melancholias, with or without suicidal tendency.

In children we note dislike of near work, *i. e.*, discomfort on accommodation resulting in inattention at school. Their school reports say that such children are quick and intelligent, but inattentive and unable to concentrate attention upon their work. The correction of the eye-strain often affects such children's standing in their classes quite magically. Many of these cases are also complicated by the presence of adenoids.

Most of the functional neuroses in children are very much improved by correction of refraction errors, *e. g.*, grimaces, frequent blinking, shutting of one eye, stammering, and nervousness and irritability. Though extremely nervous and irritable children are pretty apt to have post-nasal growths.—*The Practitioner, London.*

GASTRIC AND DUODENAL ULCERS—W. E. Deeks believes that the following chain of conditions leads up to gastric and duodenal ulcers. A sugar starch diet, to the exclusion of fruits and vegetables, ferments and forms irritating diffusible organic acids which stimulate the gastric glands and give rise to hyperacidity. On the other hand, the same diet tends to a lessening of peristaltic action, and constipation, which are followed by anemia with lowered cell resistance. The combination of hyperacidity with lowered cell resistance in an anemic mucous membrane is sufficient to bring about a loss of continuity in the mucous membrane with the attendant bacterial invasion. Mechanical irritants of any sort may assist to the same end. With this theory as to the etiology of gastric and duodenal ulcers the author has devised the following plan of treatment: In severe cases with hemorrhage, he advises absolute rest in bed and a liquid diet for two or three days until the vomiting ceases and there is no more hemorrhage either into the stomach or duodenum. The liquids should consist of orange juice without sugar, milk, and broth. Then gradually one should add eggs, meat balls underdone, fresh fruits and green vegetables cooked, particularly those of the softer kind, like squash. After six to ten days every variety of meat, fish, green vegetables, and cooked and uncooked fruit can be given. Care must be taken to exclude in every form sugar, potatoes, bread, toast, cakes, and pastry. The only medication given is dilute nitric acid before meals from the onset of the attack. It is given with the object of destroying the bacteria of starch and sugar fermentation in doses of from fifteen to twenty drops of the dilute preparation in half a tumbler of water.—*New York Medical Journal.*

A COMMON ABUSE IN THE PRACTICE OF GYNECOLOGY.—W. A. Wade considers that curettage is performed with unnecessary frequency. He believes it has been amply demonstrated that the uterus cannot be curetted



thoroughly, and that a pathologist can only rarely find in his scrapings a difference between normal and inflamed endometrium. In view of the changes which take place in the endometrium in connection with the menstrual cycle it is easy to understand that normal changes in the mucosa have frequently been mistaken for hypertrophic and interstitial endometritis.

Curettage when the uterus is actually inflamed is dangerous to life.

In chronic endometritis hysterotomy, followed by excision of the diseased glands with a small sharp curette, is proper practice. Erosions of the cervix are best treated by the actual cautery or by amputation of the cervix.

Curettage prior to plastic operations on the cervix and perineum is wrong, both in theory and practice.

The curette should not be used for the delivery of portions of placenta of foetus in post partum and post abortum cases, rather should one use the gloved finger, a sponge holder, or placental forceps, and this should be followed by the light packing of the uterine cavity with gauze moistened with tincture of iodine diluted one-half. Curettage is not indicated for such conditions as congestion of the endometrium resulting from ovarian activity.

The curette is of assistance in making a diagnosis as to malignant disease of the uterus, but as a therapeutic agent it has little value.

Probably few gynecologists of experience will agree with the opinion which has been thus expressed.

Undoubtedly the curette has been shamefully abused and many crimes have been committed with it, but in the hands of one who is skillful and experienced there is no instrument in the gynecologist's armamentarium which could be less readily dispensed with. It is well to sound a note of warning, certainly, to the unskillful and the injudicious who have done much damage by their rashness. The unfortunate teaching that curettage is a simple operation which anybody can do, has led many ignorant and unskillful physicians to attempt it, often to the undoing of their patients.—*International Journal of Surgery.*

CHRONIC PERICOLITIS AND CHRONIC APPENDICITIS.—By Dr. J. Roll (*Norsk Mag. f. Laegvidenskaben*, Christiana, 1912, Vol. LXXIII, p. 653.—The author discusses chronic pericolicitis, with details of ten illustrative cases operated upon, and shows how it may be caused by and confused with appendicitis of a chronic type. Pathologically, the patients show peritoneal thickenings and adhesions about the cecum and ascending colon. These inflammatory changes are very variable in extent, and so the symptoms are correspondingly variable and sometimes indefinite. Thus they may be mainly near the cecum and appendix, when chronic appendicitis will be diagnosed though at operation a normal appendix may be found. If they are mainly in the upper part of the ascending colon and about the hepaticocolic ligament, when they appear to be connected with enteroptosis rather than appendicular inflammation, the symptoms will be more indefinite dyspepsia rather than appendicitis will be simulated, colic and constipation will be complained of, neurasthenia may be diagnosed—the author quotes illustrative cases—and great improvement will result from rest in bed and careful feeding, with relapse as soon as the patient gets about

again. In some instances the clinical picture is complicated by nephrop-tosis, with its characteristic symptoms superadded to those of pericolicitis and colonic adhesions. He lays stress on the constipation produced by adhesions about the ascending colon; and recommends early laparotomy and severance of the adhesions before they have become too extensive (for they tend to spread) and before they have interfered too much with the structure and functional activity of the colon.

**VOLUNTARY NYSTAGMUS.**—A case of this rare condition, is that of a young man, 20 years old, about to be drafted for the army, wanted his eyes examined to determine whether he could escape service on account of a trembling of the eyes. He had first caused this “dancing of the eyes” at the age of 7 to 8, and had since provoked at will, whenever he wished to satisfy himself that he was still able to do it. The movements could be started and stopped at will, whenever he was invited to provoke them.

The movements were horizontal, sharp, and rapid, twenty to thirty in ten seconds. During the nystagmus there was marked contraction of the pupil, the pupil assuming a markedly oval shape, with the long axis vertical. The rapidity of the movements precluded the determination of a possible hippus. The moment the movements ceased the pupil again became round. Slight spasmodic contractions of the lids were also noted. In order to start the nystagmus the patient concentrated his mind on his eyes; this he could not do over a long time without causing himself great fatigue. During the nystagmus there is no deviation of the eyes. The eyes are generally in the primary position, but nystagmus is possible in all positions except the extremes. It can also be produced when the eyes are closed. During the nystagmus the vision is lowered, objects appear deformed. After a few minutes of nystagmus the patient experiences vertigo, from which, however, he quickly recovers. The patient has never had involuntary nystagmus; his vision is normal, and he is an emmetrope. There is no strabismus, no insufficiency, nor muscular paresis. The amplitude of movements is normal, and there is no diplopia, not even during the nystagmus. Family history and general health excellent. Weekers does not consider this voluntary nystagmus an example of voluntary inhibition of the cerebral centers, but as a manifestation of the nervous excitation of the supra nuclear centers for the eye movements.—*Dr. L. Weekers, Archives d' Ophthalmologic.*

WILLIAM SPENCER, M. D.

**OCULAR TUBERCULOSIS AND ITS TREATMENT.**—The author notes the great increase of ocular tuberculosis in Paris, and again commends his medical treatment of this condition. The treatment consists in the exhibition of thirty to forty drops of iodogenol a day, and the rubbing into the surface of one to two soup-spoonfulls of guiacolated cod-liver oil (cod liver oil, 120.0; guiacol, 15.0; essence of citronella, 4.0). In addition the patient is to eat 60 to 100 grams of raw beef daily, or, if the patient is in good financial circumstances, muscular juice. He considers iodogenol superior to the other iodine preparations, because it is without unpleasant odor and is better tolerated by the stomach, which is of great moment, as the treatment of the tuberculous condition extends over a long period of time.

The good results often obtained in the beginning by treating these patients by mercurial injections can be accounted for by the weakening of the virulence of the tubercle bacillus, is but temporary, and if the mercurial injections are continued the situation becomes worse. In the cases of mixed dyscrasia, where both tuberculosis and inherited syphilis underlie the eye condition, both modes of treatment should be employed, and an illustration is given in the person of a woman aged 40, whose right eye had been enucleated for a malignant iridochoroiditis which had resisted all treatment. The left eye becoming affected, she was sent to Abadie, who saw a fine vascular arborization of the iris, and gave her the mixed treatment with a good, permanent result. Of late Abadie has been treating a number of these tuberculous patients with tuberculin. In France the only available tuberculin is that furnished by the Pasteur Institute and that of Calmette. With these he has had very satisfactory results. In spite of large dosage he has never been obliged to suspend the treatment on account of local reaction. All surgical intervention should be rigidly abstained from once the medicinal treatment has been instituted.—*Dr. Charles Abadie, Archives d' Ophthalmologie.*

WILLIAM SPENCER, M. D.

ON THE USE OF RADIUM IN OPHTHALMOLOGY.—If one brings a sufficient quantity of radium in contact with the closed eye, the temple, the vault of the skull or the occiput, a sensation of light will be produced. The radium rays do not act on the retina nor visual purple; the rays have no refracting power, so that no image is thrown on the retina; the Beta rays, the most active, do not reach the retina, being absorbed by the media of the eye, hence we conclude that the radium emanations act by fluorescence of the refractive media of the eye and by direct irritation of the cortical visual center, producing an increase of visual power. The diseases to which radium can be applied successfully are external, of the eyelids, cornea and conjunctiva. It may be applied naked or filtered, but bearing in mind its powerful caustic effect, in all cases except epithelioma it should be filtered through tin, lead or aluminum. Rodent ulcers, angiomas and epitheliomas of the lids yield readily. A case of sarcoma of the brow which melted away under treatment is recorded. Trachoma and pterygium are greatly benefited or cured. Lupus of the conjunctiva and severe corneal ulcers offer promising fields of treatment. The analgesic action of radium has been frequently noted, especially in neuralgias.—*Dr. G. Sterling Ryerson. Ophthalmology.*

WILLIAM SPENCER, M. D.

THE EFFECT OF MEDICATED VAGINAL DOUCHES IN NON-PUERPERAL WOMEN.—Polano (Wurzburg) has attempted to determine the effect of vaginal douches in non-puerperal women upon the bacterial content. For this purpose he has studied the vaginal secretion microscopically and by means of culture methods. His results show that the most effective solutions were 2 per cent. alum, 4 per cent. alcohol, 1 per cent. alsol, .02 per cent. argentum nitricum, and bolus alba. Less active, but still useful were 1 per cent. lysoform, and 0.2 per cent. iodine; while 2 per cent. acetic acid, 1 per cent. lysol and 2 per cent. lactic acid were of least use. Neither the



the bactericidal power of the solution, nor its acidity, nor the alleged bactericidal power of the vaginal secretion increased by lactic acid seemed to have any determining influence. The effectiveness of the solutions seemed rather to depend upon its drying and tanning properties.—*Zeitschr. f. G. W. G.*, Vol. 70—394.

THEODORE J. GRAMM, M. D.

SHOULD PLACENTAL FRAGMENTS BE REMOVED AFTER NORMAL LABOR?—Hörmann (Munich) has been led to review the data indicating the answer to this question. As is well known it is a commonly recognized principle of obstetrics not to permit placental fragments to remain in the uterus after delivery. But Winter has recently raised objections to this commonly accepted principle and practice which he based upon his clinical experience. The author's quite thorough examination of the subject, based upon observing thirty-six cases, has suggested the following conclusions: Clinical experience, as Winter has pointed out, does not warrant the prevalent belief that retention of placental fragments frequently leads to serious puerperal fever. On the contrary, the majority of cases have an afebrile course. Exceptionally, however, such retention is accompanied by serious infection, and may be regarded as an aetiological factor. So that it is equally wrong to say that a general infection never follows placental retention.

Winter's assumption that in consequence of the removal of placental remains mild cases of fever relatively frequently become serious ones, sometimes with fatal results, is not warranted by the author's clinical observations. It is not denied, however, that such an occurrence may take place. Winter's proposal to await the spontaneous expulsion of placental fragments has not been found feasible in the majority of cases (80 per cent.) because serious hemorrhage demanded immediate intervention; neither can the proposal be carried out in private practice because of threatened and unpreventable hemorrhage. It might be possible to individualize cases if differentiated according to the bacteria present, and thus have stricter indications for operating.—*Monatsschr f. G. W. G.*, Vol. 34—412.

THEODORE J. GRAMM, M. D.

THE FREQUENCY OF SARCOMATOUS DEGENERATION OF MYOMATA.—Warnekros (Berlin) suggests, in view of the tendency to treat these tumors by the X-ray, that it has become a matter of interest to determine how frequently sarcomatous degeneration of myomata occurs, aside from necrosis gangrene of the myoma and carcinoma. This degeneration was found seven times in a series of 87 cases in Bumm's clinic, amounting therefore to about 10 per cent., which is much higher than heretofore supposed. In these cases there was often no pronounced factor leading to this diagnosis. This high percentage suggests that the greatest care should be exercised in the selection of cases for X-ray treatment, since under the circumstances early radical operation alone is curative.—*Arch. f. Gyn.*, Vol. 97—292.

THEODORE J. GRAMM, M. D.

**SARCOMATOUS DEGENERATION OF UTERINE MYOMATA.**—v. Kubinyi (Buda-Pest) says although there is still a difference of opinion respecting the indications for operating myomata of the uterus in view of these tumors being generally regarded as benign, yet we should not forget the possibility of these tumors taking on malignant degeneration. He has made comprehensive histological study of some cases, and has abundantly illustrated his article. The conclusions reached are as follows: Sarcomatous degeneration of uterine myomata is a demonstrated fact. The presence of submucous or interstitial tumors predisposes the mucous membrane to carcinomatous degeneration. Malignant degeneration especially threatens the patient during and after the climaxis. Hemorrhage and discharge coming on a year or more after the climaxis are particularly suspicious. Malignant degeneration is comparatively rare and is not to be regarded as a main indication for operating. The author inclines to treat conservatively patients under 40 years of age. But at the climacteric age and later such patients should be under medical supervision; if there is hemorrhage and discharge the uterine cavity should be explored, and any fragments removed should be subjected to careful microscopical examination. If the uterine cavity be found long or tortuous or encroached upon by tumor masses it is advisable to operate.—*Arch. f. Gyn.*, Vol. 97—327.

THEODORE J. GRAMM, M. D.

**ENDOMETRITIS AND UTERINE HEMORRHAGE**—Schickele and Keller are among the large number of physicians engaged in the study, or rather review, of this subject since Witschmann and Adler published their well known papers which tend to revolutionize our views concerning endometritis. The first named authors have re-examined the subject using for this purpose a vast amount of clinical and histological material, which, however, after careful sifting was reduced to 430 cases. This subject is strictly technical, so that the results only will be cited here. They are:

1. There is hyperplasia and hypertrophy of the uterine glands which have no relation to the menstrual changes of the mucous membrane.

2. These changes of the glands are, except in rare cases, not caused by inflammation. Consequently it is advisable in future to avoid the term endometritis glandularis, but rather to speak of hyperplastic and hypertrophic endometrium.

3. It is not possible to demonstrate an etiological relation between such gland changes and uterine hemorrhages: glandular changes may occur simultaneously with hemorrhages, but are mostly absent in severe hemorrhages, or on the other hand may be well developed without the existence of hemorrhages. But in hemorrhages as also in the changes due to menstruation, there is constantly found a hyperæmia (dilated vessels) and œdematous infiltration of the mucous membrane, with corresponding changes in the intestinal connective tissue cells.

4. The failures in results from curettement for uterine hemorrhage confirm the view that there is no relationship between gland hyperplasia, especially hypertrophy and hemorrhages.

These investigations and the contrary views expressed surely constitute a highly interesting subject to those who are following it closely, and there

can be no doubt that the matter is not yet closed; at the present stage the impression is suggested that the clinical results of the internist must also be co-ordinated with the histological findings.—*Arch. f. Gyn.*, Vol. 95, 586.

THEODORE J. GRAMM, M. D.

**BLÉNORRHOEA PROPHYLAXIS.**—Schweitzer (Leipzig) has made an interesting series of experiments for the purpose of determining the silver salt most useful for general application for preventing ophthalmia neonatorum. The nitrate, originally proposed for the purpose, has certain objections consisting in excessive reaction. The several silver salts examined experimentally were placed in solution upon the web of frog's feet and upon the transparent tail of small fish and the changes induced were studied under the microscope. The examination showed that solution of nitrate of silver displayed its cauterizing action through the entire epithelium in a very short time; with the acetate the effect was slower deeply and after neutralization the superficial alteration was but slight; argentorium and orgonin had less diffuse effect; with protargol and collargol the changes were only superficial and from using fresh sophol and argyrol the result was about the same. The bactericidal action of the acetate, of sophol and of argyrol is equal to, if not better than from the nitrate. The author believes that the acetate with neutralization fulfills all requirements of a good prophylactic against blenorrhœa.—*Arch. f. Gyn.*, Vol. 97, 101.

THEODORE J. GRAMM, M. D.

**ABORTION.**—From a statistical study of a series of 274 abortions occurring in the obstetrical wards of Johns Hopkins Hospital, Titus has found that abortions are met with in hospital practice once in every seventeen and one-third obstetrical cases. If cases having a temperature of 101° F. be regarded as infected, the incidence of infections in criminal cases is about 78%; in inevitable abortion about 60%; in incomplete abortion about 45%, and in complete abortion about 34%. The mortality is chiefly due to infection by streptococci, and averages about 10.25% of septic cases or 5.11% of all cases.

Retroposed uteri are found at the discharge examination in 20% of all abortions and is as frequent after noninfected as after infected cases. Involution is a relatively slower process. Placentitis is usually the result of infection, and occurs in about 25% of such cases. Decidual endometritis is encountered in 52% of infected and in 68% of uninfected cases. Habitual abortion is not as common as is generally supposed. More than one-third of all criminal abortions are among married women. Uterine retropositions are the most frequent cause of spontaneous abortions.—*Amer. Jr. Obs.* Vol. 65-960.

THEODORE J. GRAMM, M. D.

**VINCENT'S ANGINA.**—*Diagnosis.* Signs distinguishing it from lacunar tonsillitis are: 1. Absence of fever. 2. Pain more localized on affected side, and is severe, lancinating. 3. General malaise and physical exhaustion very marked.

*Treatment.*—First perform gentle curettage of the tonsillar crypt involved. Then apply 12 per cent. silver nitrate solution.—*Wherry*.



## Monthly Retrospect

### OF HOMOEOPATHIC MATERIA MEDICA AND THERAPEUTICS

CONDUCTED BY A. LEIGHT MONROE,

Miami, Florida.

TYPHOID FEVER.—The following case is cited from the practice of Dr. E. A. Taylor, by the editor of *Medical Advance*, October issue:

When the doctor first saw him the patient was in the fourth week of a very serious grade of typhoid fever. Delirious, in the last degree of prostration; there was coma vigil, carphologia and subsultus tendinum.

For some days previous, attacks of furious mania had occurred at intervals, during which the patient had to be held in bed. Dr. Taylor held a consultation with another good prescriber, and hellebore was administered, but without checking the rapid approach of dissolution.

By midnight the patient was plainly moribund.

The eyes were rolled upward so that nothing but the whites were visible, although the lids were open.

The head, which had been rolling incessantly from side to side, was now almost motionless from exhaustion.

The intense restlessness was failing from the same cause, but the feet and legs were still in occasional slight motion.

The arms, which had been raised high, picking aimlessly at the air, with rigid and quivering muscles, had now sunk from exhaustion to a few inches from the chest, and were still trembling.

The pulse varied between 150 and an uncountable flickering.

The margin between this man and death was a very narrow one. Life, like the column of fluid in chemical tubes, was sinking, rising, fluctuating, trembling—hesitating to leave its earthly tenement. At any given moment the heart might stop; the man was *in extremis*.

Was there any help in modern laboratory methods for this man, across whose pillow the shadow of death was falling? Any stimulant or tonic or general principle that would make death unclasp its grasp?

Trained observation of symptoms was at work, not laboratory tests, and presently a few pellets of zincum met. 30th were placed on the dry tongue of the dying man.

In ten minutes (by the watch) he closed his eyes; the rigid arms relaxed, the trembling ceased and they rested peacefully across the patient's body, and for the first time in seventy-two hours sleep visited that exhausted frame.

The patient slept all the rest of the night, and by morning was rational, with the pulse at 110 and temperature at 99. Could anything else in the world have done it? Could any other system of medicine have stepped in at the last moment and saved a life?—*The Homœopathician*.

THE EFFICACY OF A POTENTIZED HOMOEOPATHIC REMEDY IN DISEASES OF THE HEART.—In chronic valvular disease of the heart where compensation is still, at least fairly well maintained, a correct prescription is quite frequently demanded. In such cases it is amazing at times, to witness the

rapid amelioration which follows upon the administration of remedies in potency. Thus an old chronic valvular case of years' standing, in whom severe cardiac oppression with violent constrictive pain, serves to make life miserable at times, *cactus grand.* in the 50,000 potency invariably gives prompt relief. Granted that the numeration of this potency is absurdly high and that the numeral should be divided by five or even ten, it still remains that something in this ethereal product of the vegetable world has a beneficial effect. That this something resides, not in the remedy or potency at all, but in the personality of the prescriber, although perhaps flattering to the latter, seems hardly possible in the light of what is known of the power of the infinitesimal.

The homœopathic materia medica furnishes two drugs in particular, in which the symptom "palpitation of the heart from any emotional disturbance, however slight," is strongly marked. These are *calcareæ arsenica* and *lithium carb.* With the latter we have had no personal experience, but the former in high potency has proved its value on more than one occasion. *Crotalus horridus* produces a sensation of soreness or tenderness in the cardiac region, especially when lying upon the left side. This tenderness has in several cases of what we may permit ourselves to designate as heart-strain in athletes, been completely cured by the 200th and higher potencies. In cases of undoubted fatty infiltration, if not degeneration of the heart muscle, *cactus*, *arnica* and *phosphorus* in high potencies, have at least greatly improved the condition of the patient. Their indications need not here be recited, but in passing it may be observed that *phosphorus* is known to produce fatty degeneration, so that in the case of this drug at least, the materialistically inclined pathologist will admit a possible therapeutic relationship.

It is, however, in cases of failing or broken compensation, that the efficacy of potentized remedies is most strongly disputed. Our own physicians who lean toward the use of crude drugs and potencies, but ill conceal their contemptuous pity for those of us who have the temerity to prescribe a potentized homœopathic remedy, in cases of failing compensation.

In the early stages of failing compensation, pathognomonic or diagnostic symptoms are as yet much overshadowed by the peculiar individualistic symptoms of the patient himself. The constitutional state as it were, of the patient, still predominates and since the materia medicist is trained to prescribe for patients rather than for diseases, he sees in the patient not only the impending pathological breakdown, but also and what is of far greater importance to him, the image of this or that remedy of his therapeutic acquaintanceship. He thinks in terms of homœopathy, hence in the light of its fundamental principles. To him in consequence, the idea of a mere cardiac stimulant, a tonic or a prop, such as *digitalis* as it is commonly used does not for a moment occur. His aim is the restoration of the patient, not merely that of his heart. It is true that the former often depends, or appears to, upon the latter, but to the philosophical mind this view, in its last analysis, is shortsighted and narrow. Therefore, the prescriber selects a remedy whose type and genius correspond to those of the patient and so we occasionally see most wonderful cures, made by remedies such as *kali carb.*, *calcareæ carb.*, *sulphur*, *lycopodium* and others, in high potencies and based upon the totality of the symptoms of the patient, disregarding entirely the pathological state of his heart.

Now, however, it sometimes happens, that where such constitutional remedy has been given the relief which follows is of short duration.

A repetition of the remedy, even in a still higher potency, does not help matters. To the physician familiar with high potencies, this state of affairs portends ill and he usually finds that the case is hopelessly incurable. Palliation must now be resorted to and what this palliation is to consist in will depend entirely upon the therapeutic angle from which the case is viewed. It is at this point that the symptoms directly traceable to the heart, those symptoms which are indicative of the gross pathological state, become paramount and rapidly subdue the symptoms which have heretofore been prominently characteristic of the patient himself. It follows that the case assumes a mechanical aspect, in a few words, the circulatory pump has broken down and vigorous measures must be resorted to if its usefulness is to be restored. Let no one, however, deceive himself as to the permanency of such restoration. Here crude digitalis is often the only remedy and to apply a potency of it or of anything else, is sheer waste of time. To assume, however, that the exhibition of crude digitalis is not in accord with the law of similars is to advance an hypothesis not easy to defend. If we stop for a moment to study the provings of digitalis we find that one of the first effects is the slowing of the pulse. The rhythm of the heart is markedly slowed, the diastole is prolonged, while the force of the systole is increased. If the influence of the drug is continued, the pulse becomes irregular, although still slow; but this condition soon gives way to one in which the pulse is extremely rapid, irregular and weak, until the heart ceases to beat altogether. Hence the primary symptom of the slow pulse is an indication to the prescriber for digitalis; but a slow pulse is not characteristic of the condition, failing compensation, for which digitalis is commonly given. On the contrary, the pulse is rapid, feeble, irregular and intermittent. For the slow pulse and the disturbances of the liver or stomach which are frequent accompaniments, with the symptoms of epigastric faintness, nausea aggravated by the odor of food or cooking, jaundice, etc., digitalis in high or in any potency will be successful. For the later or secondary symptoms, whether these be regarded as the manifestation of a systemic resistance in danger of being overcome, or not, digitalis in crude dosage, the very dosage which will produce this state, will be required. The drug is still homœopathic, selected in accordance with the law of similars, but selected upon the later symptoms of the drug. To us it seems that among homœopathic physicians there need be no dispute concerning this point. We cheerfully subscribe to the frank statement that in proper cases digitalis in crude dosage, is not only efficacious but necessary to the prolongation of life; but we also maintain that its use in this manner is still a homœopathic one. We object, however, to classing as homœopathic those other adjuvant measures, so frequently employed, yet totally unrelated to the condition of the patient and based upon an empiricism at once confusing and bizarre.

Finally and in conclusion we maintain that the properly selected and potentized remedy should be more often relied upon by homœopathic physicians in those diseases of the heart, in which careful and truthful prescribers have obtained unquestionably brilliant results. To deny these is to betray a mind so narrow, so prejudiced, as to be unworthy of the physician to whom truth, no matter whence it comes, is of first importance.—*North Amer. Jour. of Hom.*



# THE HAHNEMANNIAN MONTHLY.

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FEBRUARY, 1913

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## THE NEWER TREATMENT OF SYPHILIS.

BY

MACPHERSON CRICHTON, A. M., M. D.

(Read before the Homoeopathic Medical Society of Washington.)

PRIOR to the introduction of the Wassermann test the treatment of syphilis was purely a matter of intelligent guess work. While doubtless it may be claimed with some degree of certainty that some patients were cured by the methods at that time in practice, many were treated far too long; but in the writer's judgment the vast majority of such cases retained their infection. The idea which once prevailed among physicians and the laity, that one attack of lues conferred immunity to new infection, is to-day regarded by syphilographers as based upon the false hypothesis of cure,—in a word, they were immune because they retained the infection.

It is quite impossible to estimate the number of cures that obtained formerly, but various investigators show an average of from 5 to 25 per cent. of cures as proven by the Wassermann test after five to twenty-five years of treatment.

The great rarity of second infection in such condition lends color to the rarity of cure. Since the establishment of the Ehrlich method of cure by the salvarsan treatment, reinfection is reported with growing frequency, and recent laboratory and clinical experience has truly proven that immunity to lues does not exist. Failure then to second attacks of lues is not due to a true auto-immunity but to the presence of previous uncured syphilis.

The treatment of syphilis is no longer the control of symptoms, but should be undertaken with the full appreciation of the disease and its vast nature; moreover it should be done with a thorough knowledge of what one expects to accomplish with the medicaments to be employed.

The amount of treatment necessary to a given case of lues cannot be arbitrarily fixed, as infections vary immensely with their genus, and again in the individual case. In some, for example, the minimum dose will effect a cure, while again others, and these are in the vast majority, will resist all treatment even when pushed to the limit.

The usual perfunctory administration of proto-iodide of mercury pills, a practice largely in vogue even at this day, rarely stamps out the disease, and leads usually to immunity of the drug. Daily one comes in contact with victims of paresis, tabes, and other sequelæ of sustained lues, all of whom give a history of two, three, or four years of "Mercury Diet." This method therefore stands condemned on sight with the present up-to-date knowledge of this dreaded malady.

The practitioner who follows the rule of treatment as laid down in even the most modern text books, will find the number of cures, certainly not on the increase. On the contrary, the percentage of tertiaries will show as high, or indeed be higher, than heretofore, by reason of the gradual but certain immunization of the race to mercury.

In the light of the results, as shown by the Wassermann reaction, few patients, if any, are actually treated and cured by the mercurys and iodides alone. Indeed, mercury immunization is established, which embarrasses further treatment, and impairs the nutrition of the patient. It is true mercury, and particularly iodides of mercury, will check late cutaneous symptoms of lues, but its persistent employment pushed to the limit will rarely if ever change the serum reaction.

The efficiency of the modern therapy of syphilis is attested by a number of experienced observers all over the world. Salvarsan is a specific spirochetal poison the efficiency of which is in direct proportion to the age of the infection, one of its greatest points of superiority over mercury, in the writer's judgment, lies in the treatment of the early cases, when it is possible to prevent secondary symptoms and positive Wassermann's, or in the event of the sero-reaction being positive, to change it to negative. The earliest possible treatment then is

the ideal method and to the best interest of the patient. This treatment should be radical, heroic, and thorough, consisting of immediate amputation of the primary lesion wherever possible, and a carefully guarded persistent employment of salvarsan or, what seems more tolerated, neo-salvarsan. This presupposes an established diagnosis through laboratory aid of the findings of the spirochete and positive sero-reaction.

One can not too strongly emphasize that in the treatment of the various stages of this disease, different problems confront us. In the early stages, one, two or three doses of salvarsan alone, or combined with mercury, completely cure the case and stamp out the infection; again, it may be necessary to push the injections to the limit of the patient's tolerance,—for example, I would cite the following cases:

CASE 1.—Patient initial lesion on prepuce, Oct. 10, 1910. First seen Dec. 1, 1910, circumcision, and injected with 0.6 grams of salvarsan, intramuscular, blood positive. Jan. 3, 1911, reinjection intramuscular 0.6 grams salvarsan. Jan 15, 1911. Blood negative Feb. 6, 1911. Last sero-reaction negative July, 1912. No secondaries.

CASE 2.—Patient initial lesion Dec. 9, 1910. Circumcision and injection Jan. 3, 1911, and April 1, 1911, 0.6 grams each time,—sero-reaction negative since Feb. 7, 1911, when its reaction was plus-minus and the mercury was discontinued and without other treatment the negative reaction was reached within a month.

CASE 3.—Patient initial lesion on finger, cauterization, and injection with 0.6 grams, March 17, 1911. Repeated same dose April 20, 1911, June 10, 1911,—blood negative. Blood in this case was ever negative, but the spirochete was found in the initial lesion.

CASE 4.—Patient. Infection showed Aug. 9, 1911, spirochete present and sero-reaction positive. Circumcision and intramuscular injection of 0.6 grams salvarsan with a course of mercurial injections begun Aug. 30, 1911. Sept. 29 and Oct. 23, 1911, reinjections and upon Nov. 23, 1911, blood negative, and has remained so ever since.

While it is demonstrated it is possible to cure syphilis within six months or so with two to four doses of salvarsan alone, or in conjunction with mercury, yet it will not do to rely too confidently upon this result. It is our habit to insist upon sero-



logical observation of our patients for twelve months at least, at intervals of not less than two months.

Excision of the initial lesion is advocated by a large majority of modern syphilographers as an aid in ridding the patient of the greatest nidus of infection, practically the original factory of the spirochete. This has been our habit for the past three years and we can heartily commend it. In former years this was largely advocated, but in those times was of indifferent value. In advising such an operation we do not, of course, contend that we rid the patient of the infection; if all the spirochetes were within the initial lesion the matter would of course end there. That it is a general systemic infection ere this lesion is demonstrable, every one familiar with the merest rudiments of lues knows, but what we do contend is that by removal of this primary infective area we at once ablate the greatest focus of infection and curtail to that extent, which is considerably worth while, the source of the infection, abolishing its greatest factory so-to-speak.

During the secondary period of this disease with a strongly positive Wassermann reaction the infection is most difficult to eradicate in a short time, yet possible even then if the more intensive treatment is instituted; by this is meant five or six doses of salvarsan, in one to six weeks, followed by a course of inunctions or injections of mercury. That it is possible to cure this disease in twelve months we have demonstrated again and again by following the sero-reaction.

As the disease grows old the difficulties we meet with in eradicating its virus grow in proportion, requiring larger and more frequently repeated doses. In such cases it requires ten to twelve doses of salvarsan with one or more courses of inunctions or injections to reverse the sero-reaction permanently, but if we pursue our treatment with a definite plan, a definite knowledge of our patient and our drug, we get results to-day that would appal the older syphilographers. Such cures are, of course, only possible in patients of the better strata of life, where one may get the best co-operation. When such conditions obtain salvarsan with the addition of mercury will eventually change the sero-reaction.

Salvarsan has a much more rapid action upon the organism than has mercury. This is readily demonstrated in cases of mucous membrane lesions and those of malignant syphilis. In the latter the extreme cachexia which characterizes the disease

disappears within two to three weeks, and lesions which have persisted for months in spite of mercury promptly recede. It is a common experience to see patients whose cases have absolutely resisted the old methods restored to health in a few weeks by salvarsan.

In controlling the treatment with the Wassermann reaction, it must be remembered that from ten to fifteen per cent. of active late manifestations of lues give a negative reaction, so that in the face of positive clinical findings the sero-reaction is to be discarded. We have seen several cases markedly benefited by salvarsan where the Wassermann has been negative.

In diseases of the nervous system, the administration of salvarsan should be undertaken only with complete knowledge of possible effects. Great prudence must here be exercised to avoid accidents in advanced nervous disease, although in properly selected cases great good may result. When salvarsan treatment is decided upon it should be given with every care and caution in small doses, and followed with inunctions or injections. In this way a gradual effect is produced, and we avoid too rapid dissolution with its dire consequences.

Intense headaches so often persistent during the second and third stages of the disease, and due to a low grade meningitis, are wonderfully influenced by salvarsan,—usually remitting promptly on injection of the drug.

The drug has been criticised owing to the relapses that have followed its use, affecting largely the central nervous system and which the critics have claimed was due to toxic action, or special affinity of the drug for the nervous system. That such views are erroneous is shown by recent investigators and the adoption of the intensive treatment followed by a greatly diminished number of relapses. The reasonable deduction is that these cases were merely true relapses.

The last word in syphilitic therapy is neo-salvarsan. This preparation bears the laboratory number of 914 and is a very soluble form of salvarsan, obtained by the addition of formaldehyd suphoxlyate of soda. It is fully as efficient as and possesses many advantages over the older preparation, in simplicity of technique and greater tolerance, permitting larger doses at shorter intervals,—thus concentrating the attack upon the disease. In cases of meningitis or in involvement of the cerebro-spinal nervous system the patient's susceptibility should be cautiously tested by small doses. Owing to its lessened irritability

it lends itself handsomely to the intramuscular method, which we regard always as the method of administration to be preferred.

Two weeks following its employment a sero-reaction is taken, and if negative, it should be repeated monthly, while if positive, intensive mercury treatment is employed followed by two or three repeated injections of neo-salvarsan.

Through the courtesy of the medical department of the U. S. A. we have had the privilege of using this new preparation for the past twelve months, and I must add with immensely gratifying results in first and second degree cases.

Of ninety-seven cases treated by Schreiber, sixty-one became negative, thirty-six remained positive. One-third of the former cases became negative after fourteen days,—five were negative after two months,—and seven after three months.

Assuming the solution of salvarsan has been properly prepared and one is familiar with the technique of its application, given a patient with intact kidneys, circulation, and nervous system, in the majority of cases the injection will cause no more disturbance than the intramuscular injection of the mercury salts.

CONCLUSIONS.—The efficiency of salvarsan bears direct relation to age of the infection.

In the early stages three or four doses of the drug supplemented by mercury will in the vast majority of cases cure the disease in from six to twelve months.

The florid stage requires the more intensive treatment; five to six doses followed by several mercury courses are here necessary.

In some forms of lues of the nervous system the effects of salvarsan are more satisfactory than mercury or iodide of potash.

In malignant lues when mercury has been given over a long period conscientiously, with no change in the clinical picture, or sero-reaction, oftentimes salvarsan will cause the picture to change clinically at once, on application of one or two injections. Such patients as are apparently immune to mercury, or their spirochetes are more sensitive to salvarsan.

A reaction uninfluenced by a long course of mercury may quickly change following one to two doses of salvarsan. In a word, the ideal treatment of to-day is the combination of salvarsan plus mercury, as it is more efficient in changing the



blood reaction than either drug when used separately. In the early stages it is possible to reverse the blood reaction with salvarsan alone, but as the disease grows older the possibility of this grows increasingly less.

The introduction into the system of great quantities of the drug, as is now possible by the employment of neo-salvarsan, may so concentrate the treatment that all or most all of the organisms are destroyed, but it has not been used long enough as yet to enable us to definitely decide this.

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## THE SYMPTOMATOLOGY OF RHEUMATIC FEVER.

BY

FLORENCE M. SEWARD, M. D., WILMINGTON, DEL.

(Read before the Delaware and Peninsula Homoeopathic Medical Society.)

ACUTE rheumatism, or rheumatic fever, is a febrile, migratory disease, liable to complicating inflammations of the pericardium and of other visceral serous membranes and to recurrences.

It rarely presents marked prodromal symptoms, but ordinarily the patient feels weary and sick, for, from one to three days. The symptoms then set in suddenly, with a chill, which may be repeated once or twice. Fever appears and the temperature rises to 102 or 104 degrees F. The pulse and respiration are quickened and the tongue is furred. There is no appetite, but great thirst. The urine is scant and loaded with urates, which gives it a dark red color. The S. G. is high, and it is not rare to have albuminuria the first days of the attack. Chemical examination shows that urea, as well as uric acid is present in excessive quantities. The skin is covered with abundant perspiration.

Simultaneously with the fever the characteristic signs of rheumatic arthritis appears, generally in the articulation of the foot or knee. After a few days it invades the shoulders, the elbow joints and the hands.

The affection occasionally begins in the articulation of the arms. When this is the case, it is usually with persons occupied in hard, bodily work. The larger joints are most fre-

quently affected, but the small joints of the fingers and toes may be affected. A single joint rarely continues to be the seat of trouble for more than four or five days; the affection then suddenly disappears, usually during the night, and one or more joints are attacked in turn.

In very severe cases almost all joints may be affected at one time and even the joints of the jaws, the spine, and the ribs may be painful and swollen.

Ordinarily, rheumatic fever attacks several articulations. But mona-articular acute rheumatism has also been observed.

The affected joints are very painful and swollen; the skin is hot, red, tense and œdematous, while pressure upon it leaves an impression which remains some time.

Swelling of the joints is principally caused by the œdema of the skin and of the ligaments, but occasionally also by an effusion in the joint itself. By moving the diseased parts, a crackling sound is sometimes heard. This is commonly caused by the inflammatory changes of the tendons and their synovial membranes.

Moving and even touching the affected joints is very painful. In severe cases the pain may be caused by someone walking over the floor of the sick room.

The pain seems to be localized in the tendons and muscles in the proximity of the articulation, and, when it is possible to induce the patient to keep completely quiet, slight movements of the diseased joints may be passively executed without causing any pain. Whereas, the most trifling active movement is accompanied by excruciating pain.

The skin over the affected area shows increased sensibility to changes of temperature, but a diminished sensibility to faradic irritation.

The temperature of the patient is raised in proportion to the number of affected articulations. In uncomplicated cases it seldom rises above 102 to 104 degrees F.

The duration of rheumatic fever varies from a few days to several weeks, or even months. It is liable to remissions and especially when the patient leaves the bed or sick room too soon. In some cases the fever declines; but one or more joints remain swollen and painful for a long time.

When the swelling subsides, the cuticle usually cracks and peels off in small scales. As many red blood corpuscles perish during the attack the patient becomes pale and weary. The

anæmia often continues for a long time after the recovery from the disease itself.

According to Sajous, an analysis of 450 cases of rheumatic fever in Charing Cross Hospital in the last seven years show that sexes were equally divided; 72 per cent. of cases occurred between ages of 10 and 30 years. Heredity seems to have been active in 22 per cent. of cases. The seasonal maximum was in May and November. The knee and ankle were nearly twice as often affected as any other joint. Endocarditis occurred in 28 per cent. of male and 33 per cent. of female.

The diagnosis is usually easy. Gout may be diagnosed by the fact that the temperature never reaches the height of that of rheumatic fever.

It might also be confounded with the secondary multiple inflammations of joints observed in many acute cases, such as scarlatina, rubiola, diphtheria and pyæmia, and also with pseudo rheumatic affections of gonorrhœa, syphilis and tuberculosis. In all these affections the symptoms of the major infection aid in making the diagnosis.

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#### PAROTITIS COMPLICATING APPENDICITIS.

BY

N. F. LANE, M. D., PHILADELPHIA.

IN the May number of *Surgery, Gynecology and Obstetrics*, Frank, of Chicago, reports a case of this nature and in a review of the literature states that he could find but sixteen cases reported and concludes that it must be a rather rare condition. Granting this to be correct I wish to report a case that came under my observation last year.

Miss C. was taken ill in the early part of May, 1911, with an attack of appendicitis. She recovered symptomatically in a few days, but upon getting out of bed she was again attacked with pain and some fever. On May 13th I was asked to see the patient by her medical adviser, Dr. Paxson, and found a subsiding appendicitis and recommended a continuance of the Murphy treatment until the acute symptoms subsided and then to operate.

On May 16th she was so much better that she was removed



to the hospital and prepared for operation the next day, but that morning the swelling of the left parotid gland began, accompanied by fever and the operation was postponed. On the 23d she had a leukocytosis, but the exact count I do not recollect. On the 24th, six days after the swelling was first noticed, and before there was decided fluctuation, the gland was incised under nitrous oxide anesthesia and considerable pus evacuated. A small drain was inserted for a few days and then it was allowed to close.

On June 5th she was again prepared for operation and the appendix was removed. Upon opening the abdomen in the right semi-lunar line, the cecum was found surrounded by light adhesions and after protecting the field of operation with gauze pads, the adhesions were broken up and the appendix was found low down in the pelvis. When the attempt was made to separate the appendix from the adhesions it was found to be gangrenous at the base at which point it separated entirely from the cecum and it was with some difficulty that feces were prevented from soiling the operative field. The hole in the cecum was closed with a purse string suture of chromic catgut and this buried with two layers of Lembert suture of Pagenstacher thread. The appendix was then removed piecemeal and a small cigarette drain carried to the seat of operation. The wound healed by first intention except where the drain was introduced. Her recovery was uneventful.

She was well and had no further trouble until late in the summer, when a small sinus opened at the point of drainage. This was treated by a local physician, but did not heal. When she returned to the city I removed a linen suture from the bottom of the sinus by means of a small hook and it healed promptly. She has been in excellent health since.

The relation between the infection of the appendix and the infection of the parotid gland I will not attempt to discuss as there seems to be a difference of opinion in regard to this question. Is it a hematogenous infection; an infection through Steno's duct, or are these cases only coincidences? All these theories have been advanced, but it seems to me that the hematogenous theory is the only logical hypothesis.

## Transactions of the Homoeopathic Medical Society of the State of Pennsylvania.

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### BUREAU OF MATERIA MEDICA

WILLIAM A. SEIBERT, M. D., Chairman

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#### ADDRESS OF CHAIRMAN—A SYMPOSIUM ON BELLADONNA.

BY

WILLIAM A. SEIBERT, M. D., EASTON.

THE purpose of this symposium is to accentuate the fact that drugs produce symptoms in all parts of the body, and act for the cure of disease in all parts of the body; that specificity applies to symptoms rather than to disease; and if possible to draw attention to the kind of work that remains to be done in the scientific elaboration of the wonderful relation these phenomena bear to each other.

To convince that belladonna produces symptoms it is only necessary to take it. Few drugs have been more carefully and scientifically proven than belladonna. More provings will, of course continue to enrich our *Materia Medica*, and may do so *ad infinitum*, but the further investigation of the effect of the various potencies upon the healthy, and the effect of repetition at various intervals, and a study of the susceptibility exhibited in the various provers, and the reasons therefor, or at least their explanation—these are fertile fields for us still to cultivate.

The contributors to this symposium bear witness to the fact that medicines properly applied prove curative in disease, and they will recite numerous clinical verifications of the symptoms produced by belladonna. If these men are not poor deluded fools, those who claim that drugs do not cure disease can be put into a class by themselves.

Those who still believe that drugs cure disease must not stop because of the fascinating methods they are pursuing, and

the interesting results these nihilists are attaining in the laboratories. Their conclusions generally are refined hygiene, or a physiological or pathological corroboration of the homœopathic symptom, if not the development of a poor kind of homœopathy itself. These are not mean scientific collateral refinements, and they regularly seem to strengthen the fundamentals of similia, but they are only side-props and must not be allowed to supplant or absorb the real structure. "A rose by any other name will smell just as sweet," but let us not mistake and acknowledge a cabbage for a rose.

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#### PROBABLE EXPLANATION OF ANTITHETICAL SYMPTOMS AND PROPHYLAXIS.

BY

AUG. KORNDORFER, M. D., PHILADELPHIA.

ACCORDING to our provings belladonna is marked by many so-called opposite or rather antithetical symptoms which, if not understood may lead the prescriber far astray. Illustrative of these antitheses we may note the following: "Memory active and retentive": "memory impaired, forgets in a moment what he was about to do." "Talkative then mute." "Quarrelsome during exuberant mirth." "Photophobia," or the other extreme "Photomania." "Hearing oversensitive" is frequently observed, yet "Deafness as if a skin were drawn over the ears," is equally important. "Extreme sensibility of smell" or the reverse, "Sense of smell lost." "Sleepy, yet cannot sleep." "Face flushed and hot," or "pale and cold." "Convulsions." "Paralysis."

These few opposite symptoms and conditions will suffice to illustrate the importance of further study, both in the laboratory and at the bedside, that we may be enabled to define with accuracy the conditions under which these and other apparently paradoxical symptoms meet the requirements of the law of cure as expressed in the formula "*similia similibus curentur.*"

It is only through such critical analysis that we can hope to remove the uncertainty now beclouding the mind of many an earnest seeker after therapeutic accuracy. In addition, through such definitive work we will be enabled to purge the patho-



geneses of some of our remedies of redundant as well as misleading symptoms.

Dr. Hering used to say, "When clinical verifications have sufficiently accumulated the time will have arrived for winnowing the wheat from the chaff, but," he would add, "the harvest time is not yet."

Had he lived to see the laboratory of *Materia Medica* of our (his) Hahnemann Medical College, recently endowed by his son Walter Hering, he surely would have rejoiced in this day of great things for the college that he established and for his beloved homœopathy.

Hering also appreciated the fact that our *Materia Medica* needed an analysis whereby the physiologic interpretation of drug symptoms might become possible, for he frequently remarked, "Our *Materia Medica* will give us a new physiology and that will open the way to a new and true pathology." The laboratory will, indeed, afford efficient aid in our efforts to reach a solution of some of our unsolved problems; nevertheless we dare not rely upon it implicitly, for, as Abrams says: "It is not now unusual for the laboratory physiologist to preside at the birth of his theory one day, and for the clinician to officiate at its burial to-morrow"; or, as Pavloff expresses it, "The physician gives a more correct verdict concerning physiologic processes than the physiologist himself."

Much has been done, however, to unravel the mysteries of drug action, as well as of disease. The Roentgen rays, radium, radio-activity and other wonders in the realm of physical science, have opened the minds of honest doubters and have rendered many investigators receptive of hitherto rejected truths, thus opening the way to an understanding of phenomena otherwise unexplainable, and leading to discoveries that have strengthened our cause.

We find abundant evidence of such development in the more recent researches relative to drug action; and if our laboratory workers possess the power of initiative necessary to the development of experimental research along new and original lines, much may be accomplished for homœopathy. Merely following in the wake of the old school investigators will, however, bring but poor return. The methods of research must be adapted to a different end and require for their development a thorough knowledge of Hahnemann's philosophy before the investigator will be competent either for work or witness.

If we analyze the symptoms of belladonna in the light of their physiologic significance, we shall see that even the apparently contradictory symptomatic effects help to form a harmonious picture of its complete pathogenetic power.

Sajous, in his monumental work, "The Internal Secretions and Principles of Medicine," gives us a logical and philosophic study of belladonna which, though brief and incomplete from the standpoint of Hahnemann, nevertheless is based upon the results of such a scientific study of the physiologic relation of the ductless glands and the pituitary body, and their function in the life process, that the conclusions reached may be relied upon. We must note also the fact that these conclusions tally with the results of the clinical experience of our best observers from Hahnemann to the present.

Research during the past two decades has demonstrated that many apparently paradoxical conditions observed in health and in disease, are but parts of the harmonious action of the various organs, governed or regulated in their functional activities by the anterior and posterior pituitary through their control of the ductless glands and their secretions. Sajous says: "The anterior and posterior pituitary bodies are the general centers which actively sustain cellular metabolism. The anterior pituitary insures oxygenation of the blood and all oxidation processes; the posterior pituitary adjusts the vibratory rhythm of all nervous impulses which incite and govern functional activity," consequently "they govern to a large degree the control of all toxic waste products," the elimination of which is so largely a process of oxidation.

True to the pathogenetic effects first revealed through Hahnemann's provings, and in confirmation of the views advanced by Sajous, we find belladonna producing symptoms proving that it acts markedly upon these centers. Sajous says: "By its action on the test organ and adrenal center belladonna increases the proportion of adrenoxidase in the blood, while by its action on the sympathetic center it enhances the blood propelling power of the arterioles. As a result the capillaries of the entire organism are traversed by a supra-normal quantity of arterial blood unusually active in oxidising properties. Hence, the sensation of warmth in the skin and mucous membranes and the rise of temperature and transient flushing, observed even when small doses are taken." "When the dose is

large various symptoms due to hyperæmia and hypermetabolic activity in the organs influenced are witnessed."

This explains the scarlatinal redness so characteristic in our provings of belladonna, and furnishes a rational physiologic explanation of its known beneficial effects in scarlatina and the various other forms of disease with which it stands in homœopathic relation.

Just a word in reference to the autoprotective power of the human body. Very briefly and inadequately summarized, Sajous's views may be expressed as follows: The pituitary body is composed of two lobes, an anterior or glandular lobe and a posterior or neural lobe. Imbedded in the partition between these two lobes is a structure bearing a striking analogy to the osphradium or test organ of mollusks and other invertebrates, an early prototype of the pituitary. The anterior and posterior lobes with the test organ constitute an organ of special sense protecting the body against the harmful effects of poisons of all kinds. The test organ, readily excited by the presence of any form of toxic substance in the blood excites the adreno-thyroid center which in turn stimulates the adrenals as well as the thyroid and parathyroids to increase their secretions. That of the adrenals is carried into the blood by way of the suprarenal veins to the vena cava; converted into adrenoxidase in the lungs it reaches the general circulation and excites the spleno-pancreatic secretion thus increasing the amount of trypsin in the circulating fluids and in the tissues. To this substance, trypsin, we must attribute "the main prophylactic function, namely, that of a proteolytic ferment capable of reducing bacterial toxins, toxalbumins, vegetable poisons and venoms." The thyroid and parathyroid secretions jointly form the opsonin agglutinin of the blood. The test organ, by increasing the functions of the adrenals enhances "the bacteriolytic and antitoxic powers of the blood and its phagocytes; by increasing the functional activity of the thyroid and parathyroids, it increases through their secretions the sensitiveness of all cells, including bacteria, and their vulnerability to phagocytes." Thus we find that the adrenal system which is composed of the pituitary body, the adrenals and the thyroid apparatus constitutes the immunizing mechanism of the body. So brief an outline conveys but a meagre view of Sajous's epoch making discovery, but the time allotted this paper forbids dwelling longer upon this phase of our subject.



Belladonna, we have seen, is quite capable of setting this train of functional activities in motion.

This view of the action of belladonna also affords a physiologic interpretation of many of the symptoms observed in our provings, as f. i., the headache with fulness and throbbing in the carotids; the cloudiness of mind as if intoxicated; the giddiness; the talkativeness; the violent delirium with disposition to bite; the visions of ghosts, hideous faces, monsters and insects; the accelerated pulse which is usually full, hard and tense; as well as many other of the recorded symptoms.

In this connection note the fact that while a given dose will arouse the reactive forces, stimulating them to increased energy, an excessive dose gives rise to marked depression, thereby manifesting the opposite or antithetical symptoms that have been so perplexing, but which are developed through the more intense pathogenetic action of the drug upon the nerve centers—just as depression follows overstimulation whether it be physical or psychical in origin,—alcohol, tobacco and revelry afford well marked illustrations of such effects.

Many of the so-called opposite symptoms of belladonna are attributable to just such overstimulation of the pituitary, either from an excessive single dose, or from frequently repeated small doses.

We can utilize this knowledge to the advantage of our patients by regulating the potency and dose in accordance with the preponderance of symptoms of stimulation or depression manifest in a given case. In the more commonly characteristic belladonna patient, the symptoms are indicative of the initial stimulation of the pituitary and adrenals, in such cases potencies from the sixth decimal upwards will prove most serviceable. In cases manifesting the symptoms of depression, such as pale, cold face; weak and irregular pulse; shallow and irregular respiration, as observed in some cases of alcoholism, the lower potencies or even small doses of the tincture will prove more efficacious.

Great caution must be exercised in the repetition of the dose, else ill effects will result, the medicinal excitation becoming too intense for physiologic reaction. The first sign of aggravation must be the signal for cessation of medication; whereas amelioration should promptly suggest lengthened intervals and diminished dosage, or, in case of marked improvement, discontinuance of the remedy. When appraising the value of symp-

toms and interpreting their meaning and significance we must remember that existing pathologic conditions will often afford a useful key. Thus, for instance, in the nervous and cerebral affections of belladonna we find marked oversensitiveness of smell, depending upon irritation of the cerebral centers, whereas in the catarrhal rhinitis calling for belladonna the sense of smell may be lost by reason of the obtunding effect of the congested and swollen mucous membrane upon the nerve termini in the region of the upper turbinal bones and the adjacent portion of the nasal septum. Thus, it may be plainly seen that a remedy having such wide field of action as the belladonna and such positive effect upon the oxidation centers, may readily manifest in its provings quite diverse and even opposite symptoms; which fact may depend upon the dose employed, or upon the intensity of its action being manifested more directly either upon the nervous system or upon the circulatory apparatus, in accordance with the individual susceptibility or idiosyncrasy of the subject.

Finally, an analysis of each case in accordance with Hahnemann's "Directions to the physician for discovering and tracing out an image of the disease," including all its antecedent and concomitant factors, *Organon*, Sec. 84 to Sec. 99, will demonstrate, not only the correctness of his method but at the same time will enable us to trace the relation between such antithetical symptoms in both patient and remedy,—thus pointing the way to the true simillimum and guiding in the question of dosage.

The totality of early and late symptoms often will show that the course of the disease has been in exact accord with the pathogenetic effects of a well proved remedy in which the sequence of symptoms indicative of functional stimulation and depression has been noted. By such means we may confirm, not only its homœopathicity to the given diseased condition, but in addition we will acquire a reliable guide to the selection of the potential dosage indicated by certain well defined groups of symptoms.

**SOME INDICATIONS FOR THE USE OF BELLADONNA IN SURGERY.**

BY

J. H. MCCLELLAND, M. D., PITTSBURGH.

IT will be the object of this brief paper to indicate some of the uses of belladonna in surgical diseases, or the complications that may arise in surgical cases.

Erysipelas has long been classed as a surgical disease, and the first blush of invasion is the call for this drug. Objectively and subjectively this diffusive inflammation is a picture of the pathogenetic effects of belladonna. The bright red suffusion of the skin, smooth and radiant, not infrequently met with in erysipelas, finds its counterpart in the fiery outburst that marks the poisoning of this drug. The sensations or subjective symptoms are heat, throbbing, and, according to location, more or less pain. The temperature and blood-pressure are high, and there is more or less stupidity. Belladonna will certainly mitigate and very much curtail a case of this type. The extraordinary affinity of belladonna for the meninges of the brain, also the eyes and throat, will suggest its use in many cases where these parts are involved.

Localized inflammation in almost any part of the body may call for belladonna. Pain, heat, redness, and swelling, the old classical quartette, being the all-sufficient indications for its timely use.

After operations there sometimes supervenes a sudden rise of temperature, with perhaps headache and supersensitiveness to noise and light. It may be an after effect of the anæsthetic, or a more local cause, and while it is always wise to seek the cause and remove it, still it will be found that the exhibition of this valuable remedy is exceedingly helpful, and assists in dispelling the morbid conditions.

One finds, say after a laparotomy, an excessive sensitiveness of the abdomen, to touch and movement, more acute, we will say, than that calling for arnica (an invaluable remedy), and then likely a greater or less elevation of temperature,—here belladonna is surely called for, and will certainly bring relief, probably heading off trouble.

The dysuria, at times following operations (not quite so



acute as that calling for cantharis) is often promptly relieved by belladonna.

Altogether this is a drug invaluable in surgical practice and answers with promptness the indications so well known to the general practitioner.

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## THE VALUE OF BELLADONNA IN MENTAL AND NERVOUS DISEASES.

BY

C. SPENCER KINNEY, M. D., EASTON.

SITUATIONS rarely occurring in other departments of medicine often confront us in the medical treatment of mental diseases. We frequently have before us a patient who by reason of the changed mental state, is not capable of intelligently giving a connected account of his symptoms in any direction. We are consequently forced to rely largely upon the importance of the objective symptoms presented by the patient.

In these notes I shall therefore give more prominence to the objective symptoms in relation to belladonna. We all recognize that a belladonna patient has the flushed face and dilated pupils, restlessness with the desire to be doing something, either striking, tearing, or biting, and these paroxysms are frequently accompanied by loud laughing or screaming, and by a pulse that strikes the finger sharply, going up frequently to 130 and 140. The belladonna patient has no thirst.

The symptoms of belladonna are of functional rather than organic change; they point particularly to congestive states, and the nerves of special senses are intensely hyperæsthetic and may be inflamed. Among the voluntary muscles, tonic and clonic spasms occur; involuntary fibers may be relaxed or in a state of rigidity. This we may note in the sphincters, the dilation of the iris, palpitation of the heart, and throbbing of the arteries.

The mood of the belladonna patient changes rapidly, being angry one moment and laughing the next, quiet and then noisy, and in severe cases the delirium is attended by hallucinations of sight and hearing, and when these are exhibited the condition is generally followed by profound prostration physically, with grinding of teeth and great mental confusion. Disconnected

mental states as evidenced by such moods are very prominent indications for the use of belladonna. A wealth of ideas show themselves in speech and conduct. There is hardly any mental condition of excitement which is not represented from time to time by belladonna patients, even to the stripping themselves of all clothing and dashing out into the street; but this excitement is not always accompanied by a sexually disturbed state of mind as in the hyoscyamus case.

Frequently patients become terrified upon closing their eyes, a terror arising from hallucinations, or illusions as they may sometimes be, which are the natural result of the disease. A confused mental state with moaning and a restlessness indicative of pain, may frequently point to retention of urine; this condition should be very carefully watched in all belladonna patients.

The memory may be remarkably accurate or temporarily lost. The past may be recalled without effort while the circumstances relating to the present may be only a blur. A belladonna patient hides herself, and may suddenly be taken with a weariness of life and attempt to throw herself into the river. Picking at the bed clothing, looking for something, muttering to themselves, are marked symptoms of belladonna.

The changeableness of belladonna is a strong indication for its employment; to be merry and then angry; to be excited and noisy, then depressed and crying; combative and then timid; satisfied with everything, exalted, and then depressed and suited with nothing immediately after. Whatever the belladonna patient does may be expected to be done quickly. She may talk freely or say nothing, but the tendency is to talk very rapidly while in the restless state. These patients are very sensitive to light, motion, noise, jars or irritations of any kind; too many in the room being a cause of marked irritation.

While in a depressed state, a desire for rest, quiet, and a solitude merging into despair is characteristic of this drug; the imagination dominates, and there is a strong desire to get away from imaginary difficulties and irritations, whether they be people or conditions. The restlessness is extremely marked, sleeplessness is pronounced, as the thoughts are too active and in too much of a turmoil to allow sleep. Frequently the patient passes his hand about his head as if he were feeling badly, or as if he were bewildered; pressure relieves.

Giddiness, throbbing, rush of blood to the head, a disturbed

vision, and vertigo, are marked symptoms of the belladonna patient. The head pains most characteristic are those that come suddenly and go suddenly, or re-occur at regular intervals, generally the right side with pressure on forehead as if the whole head would be forced asunder; pains in right temple frequently accompanied by quivering of isolated muscles, and with toothache and sensitiveness, these pains often being of a burning character. In the belladonna patient you have your congested states, your restlessness, your fever; excitement that is maniacal; face flushed to the extreme; the changing moods with intervals of quiet.

Great depression, apathy, indifference to every external condition, dryness of secretions during excitement as indicated in the parched lips, the sordes and white tenacious mucus, all point to belladonna.

When it comes to the potency to be used, this is a matter for individual decision. In my experience no single potency administered in a half dozen cases presenting practically the same symptoms, has brought about similar results. With one patient the third would act quickly and well; then again the 30th and 200th have given complete satisfaction, where the 1st to the 3d were productive of no results.

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### BELLADONNA IN THE PRACTICE OF OTOLOGY.

BY

JOSEPH V. F. CLAY, M. D., PHILADELPHIA.

THE selection of a remedy, to be applied homœopathically in disease of the ear, should be made not alone upon the aural manifestations, but with careful consideration of the general or associated symptoms. Frequently the associated symptoms are of the greatest aid in differentiating the remedy. In this symposium we have a series of papers covering the sphere of belladonna upon the various organs so that my remarks must be confined to a consideration of the aural symptoms of the drug we are studying.

In prescribing for an aural case, we have found that a routine system of interrogating the patient is most useful not only in arriving at a diagnosis, but also in the selection of the homœopathic remedy. Disturbances of the aural apparatus are at-



tended by a symptom complex, several symptoms of which are present in every case. These symptoms are pain, dull hearing, tinnitus aurium, discharge, sensation of stuffiness or fullness in the ears; and, more rarely, vertigo of the rhythmical rotary type with nausea and vomiting. By carefully considering each one of these symptoms in detail—its character, location, ameliorations and aggravations, relation to other symptoms—we are frequently enabled to make a tentative diagnosis, to be confirmed by objective examination. We then have a strong symptom complex upon which to base a homœopathic prescription.

Belladonna attracts the specialist because of its wealth of head symptoms, the meninges, eyes, ears, nose and throat. These structures frequently become the final localizing seat for an inflammatory invasion. A careful survey of the pathogenesis of belladonna, compels the attention of the homœopath to the marked similarity to certain inflammatory conditions which attack the aural tract.

Belladonna is suggested where the pain is neuralgic. It comes and goes suddenly; it is aggravated when the patient assumes the recumbent position; it is usually found to be worse from early afternoon to midnight. This symptom complex is characteristic of a very large percentage of the cases of acute inflammatory diseases of the middle ear tract, and this may be a simple tubal catarrh, acute catarrhal or suppurative otitis media and acute exacerbations of chronic suppurative otitis media. Where belladonna is indicated, the hearing is at first hyperacute, as evidenced by over-sensitiveness to mechanical and musical sounds; later this is displaced by dull hearing as the congestion increases. Autophony, or hearing one's voice in the ears, is present and frequently with this, tickling and pain along the neck between the mastoid process and the angle of the lower jaw. Tinnitus aurium is present and its character varies: it may be ringing, buzzing, whistling, humming, snapping, or fluttering. This symptom is one which clinically varies so much that it is of questionable value except as a common symptom. Upon examination the drum is found retracted, or is injected about Schrapnell's membrane; there may be a diffuse pink reflex. In cases which have progressed a little further, slight bulging of the drum will be seen. This is the type of case which, if left alone, will suppurate. Perforation will now occur, then, added to the symptomatology will be discharge varying from serum to seromucous. Clinically, we have

found when the discharge becomes mucous other remedies are indicated, such as pulsatilla, hepar, mercurius, kali bichromate, hydrastis, etc.

In inflammatory conditions of the external ear, we have found little use for belladonna. The provings speak of localized spots of redness, but this was not a marked or constant symptom. We have other remedies which act more surely upon this portion of the ear.

In acute congestion of the mastoid, as evidenced by spots of tenderness along the anterior border of the mastoid, belladonna is a valuable antiphlogistic; and, in many cases should be given in preference to capsicum which everyone thinks of as soon as a patient develops symptoms in the mastoid. In fact, we have seen many cases of acute mastoiditis subside under belladonna.

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## THE USE OF BELLADONNA IN DISEASES OF THE CHEST.

BY

WM. RENDELL WILLIAMS, M. D., PHILADELPHIA.

THE value of belladonna in diseases of the chest, depends very much upon the way it is used, hence it is not altogether inappropriate that the title of my contribution to this symposium should vary somewhat from the accompanying papers and be designated: "*The Use of Belladonna in Chest Conditions.*"

Belladonna is a drug that illustrates the fact that neither the mere matching of symptoms and administration of small quantities of a highly potentized drug, nor, on the other hand, the exhibition of massive doses of the crude drug—that neither of these methods exhausts the therapeutic possibilities of a drug. There is a middle ground wherein many valuable therapeutic results may be achieved. I refer to the use of the lower potencies in small, frequently repeated doses, sufficient to get results just short of the physiological effect, and to maintain such an action.

The wise therapist knows that different results are to be expected and obtained with the intelligent use of most drugs, by any of the three different methods outlined. For instance, it is very apparent to us all that different results are to be ex-

pected in the exhibition of belladonna 30th and belladonna tincture, and conversely, we would give them in the presence of different indications. And it surely is the height of folly, and the mark of narrowness, to confine one's usage to either of these methods. It limits one's therapeutic resources, and is not just to the patient.

In my hands the use of belladonna in chest conditions has given the best results when used as indicated, in frequently repeated doses of the lower potencies, and I have learned to regard it as one of the most—if not the most—valuable single remedy in acute respiratory affections, and nothing could be more exquisitely homœopathic in its action.

A study of the provings of belladonna, and cases of poisoning by it, show its action to be largely upon the nervous system, from the cerebral cortex to the terminal nerve endings. We are particularly concerned with its action upon the peripheral nerve endings controlling the glands, capillaries and delicate muscles of the bronchial tree. Under its influence the mucous membranes become dry and congested, their secretions become sticky, viscid and tenacious. Consider the possibilities in the respiratory tract with its mucous lined tubes, the trachea, bronchi, and bronchioles.

From a clinical standpoint, when, as the result of that common combination of circumstances—exposure, irritation, lowered resistance—infection gains a foothold on the mucous membranes of the respiratory tract, note the preliminary congestion, turgescence, dryness from scanty, viscid secretions, and later the reaction as shown by the outpouring of thick yellow muco-purulent secretion.

All these phenomena are visible in the nose and throat and obtain throughout the mucous membrane lined trachea and bronchial tree.

Now prescribing from a purely pathological standpoint for the preliminary stage of the foregoing phenomena it is certainly good homœopathy to select a remedy that will cause similar conditions. Clinically, this condition would be called an acute tracheitis and bronchitis. And it is in the first 48 to 72 hours of this condition, when subjectively the patient complains of substernal oppression, dry, painful, racking paroxysmal cough—when objectively we find a feverish patient with increased respiration, diminished respiratory sounds and later small, sticky, sibilant rales scattered throughout the chest



—that belladonna is indicated, and will not disappoint if properly given. And it is not well to discontinue the remedy too soon. Give it throughout the acute stage at least—so long as active inflammation seems to be present. Later, in my experience, the substitution of ipecac is usually indicated (or it may be given intermittently) when the finer bronchioles are affected, as shown by the small and medium sized rales.

In children it is frequently the only remedy necessary in acute bronchitis, and given as I have indicated, often averts or at least modifies the later stage of profuse expectoration. It is particularly valuable in children when we have, as we so often find, an asthmatic tendency. Here we have in addition the antispasmodic action of belladonna demonstrated. This thought leads to a consideration of belladonna in asthma.

Asthma is best defined as "a paroxysmal dyspnoea from disturbed innervation of the bronchi, leading to spasmodic contraction of these tubes." (Powell & Hartley.) This theory is not universally accepted, many contending that the paroxysm "is due to a sudden swelling of the bronchial mucous membrane from turgescence of its blood vessels." Even the latter theory implies instability in the vasomotor innervation. At any rate there is always a distinct nervous factor present. Brodie and Dixon caused constriction of the bronchioles, due to peripheral stimulation of vagal nerve endings, by injection of muscarin and pilocarpine, and relieved by paralyzing these same nerve endings with atropine, hyoscyamin and hyoscine. And they also point out the fact that the bronchial mucous membrane is different from the nasal mucous membrane in that it is thin and has a relatively insignificant blood supply, and hence it is illogical to expect the sudden and marked vascular engorgements that may take place in the cavernous erectile tissue as found in some parts of the nose.

At any rate, be the cause of the asthmatic paroxysm found in the bronchial mucous membrane, or central—as in some circulatory conditions which give rise to an excess of carbonic acid in the blood—or reflex—as illustrated by those numerous cases traced intranasal conditions—be the cause what it may, the sedative action of belladonna on the terminal filaments of the vagus supply of the bronchioles make it a valuable remedy in the acute condition, and also one often used beneficially over extended periods between paroxysms.

The action of belladonna in pertussis is too well known to

need further comment. It has given the best results, in my hands, of the multitude of remedies I have tried. Here again we rely on its sedative effect upon the terminal nerves.

Belladonna in small doses is a distinct stimulant to the respiration. In large doses a paralyzant. This fact together with its action upon the mucous membrane and capillary circulation has led me to use it as an intercurrent remedy in pneumonia, particularly in those cases characterized by a tendency to edema of the lungs, and in cases where there is a free exudation into the bronchi, as shown by moist, bubbling rales elsewhere than in the consolidated area. We all know how much better the dry pneumonias do than the moist ones. In other words, the presence of a bronchitis is always a serious complication of pneumonia and of grave prognostic significance.

In pneumonia the drug has another beneficial effect, I am convinced, in that it tends to maintain the blood pressure and keeps the superficial capillaries well filled.

In true pulmonary edema the action of belladonna is too slow. Here the best results are gotten from its alkaloid atropine sulphate combined with morphia.

A few words on the action of belladonna in cardiac conditions is appropriate in discussing diseases of the chest.

Belladonna acts on the heart through the vagus, its inhibitor, and possibly by some stimulative effect on the accelerators. Therapeutically it may be useful when there is irregular action due to vagus irritation, as seen in some cases of influenza and other infectious diseases, and where the irritation arises along the gastro-intestinal tract. Occasionally in the presence of extra systoles due to the same cause.

It may be combined with digitalis to advantage for its steadying effect and where flushing of the superficial capillaries is desirable.

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#### THE VALUE OF BELLADONNA IN GENITO-URINARY DISEASES.

BY

LEON T. ASHCRAFT, A. M., M. D.

A STUDY of the pathogenesis of belladonna shows its value as a remedial agent in urology. In a general way we are all acquainted with its symptomatology and the indications for its employment. From my point of view, however, I prescribe

it for the acuteness of the pathological condition, that is the localized inflammation and associated nervous phenomena. Acute urinary infections are always associated with inflammation and consequent excitement of the sensitive nerve filaments. Now, when we consider the rich endowment of blood vessels and nerves supplying the genito-urinary tract the picture as presented by belladonna suggests its use. No portion of the nervous system is exempt from the action of this drug. The active congestion manifested by excitement, perverted special senses and twitchings, the hot, red face, glaring eyes, throbbing carotids, hyperæsthesia of all senses, delirium, restless sleep and violent headache, make an exact similitum for acute urinary fever and urosepsis.

This remedy is incomparably superior to the ordinary antiseptics as cystogen and urotropin. I have frequently seen a temperature of 104 F. and all symptoms of severe infections disappear following its employment.

It is of decided value in hematuria, particularly that type known as essential hematuria where no pathological condition can be found to account for the bleeding, also in hematuria of vesical origin, where, as shown by cystoscopy, the bleeding comes from the varices or from ulcerated surfaces of the bladder or from new growths.

It is also of value in the sub-acute bladder inflammations of women, which are worse during the menstrual period, and sometimes when given in appropriate doses controls urinary incontinence dependent upon muscular paresis following bladder operations.

Belladonna shows marked tenesmus and sensitiveness of the vesical region, the urine is dark, turbid and loaded with phosphates.

In severe cystitis requiring constant irrigation, I usually prescribe belladonna because I find that instrumentation is better tolerated by the soothing effects of the drug upon the hypersensitive nerve filaments.

Perhaps the greatest role for the employment of belladonna is in diseases of the prostate. To be sure, it will not cure prostatic hypertrophy but it will relieve the acute congestion of this organ which results from cold and which may lead one into making a diagnosis of hypertrophy. It is of decided value in inflammation of the prostatic urethra.

I use belladonna as a rectal suppository. I have been dis-



appointed with this drug in acute and chronic infections of the anterior urethra. Acute epididymitis, however, is frequently relieved by its use.

My experience with belladonna in chronic urinary conditions has not been as gratifying as when the drug was given for acute conditions, although I remember a case of renal varix which defied catheterization and therapy and responded to belladonna. I have, occasionally, found it of value in tubercular cystitis and particularly efficacious in acute gonorrheal arthritis.

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### BELLADONNA IN DERMATOLOGY.

BY

RALPH BERNSTEIN, M. D., PHILADELPHIA.

HYPERAEMIA and hyperaesthesia of the skin are the principal effects of physiological doses of belladonna upon the human economy, which effects are presumed to be the results of the toxic influence of this drug upon the centers of the nervous mechanism.

Belladonna aggravations always occur from draughts of air, from touch, change from warm to cold air, and from direct warmth. If congestion is decided or long continued, the skin of the face becomes dry and puffed, which may at times be associated with desquamation.

It must be borne in mind that belladonna is chiefly of use in dermatologic affections in the very early stages of cutaneous hyperaemia, and especially in those who are full blooded. Belladonna does its best work in from the third to the sixth decimal. It is useful in acne, eczemas of the erythematous type, erysipelas, herpes zoster, rosacea, and the following erythemas; scarlatinaforme, multiforme, nodosum.

*Acne.*—Belladonna has demonstrated its usefulness in acne in the very early cases in those who are full blooded and who are subject to attacks of hyperaemia of the face with sudden flushing which remains for a time and recedes very slowly. The papules are bright red with areas of erythematous skin between of a lighter hue. The sensations are those of stinging and marked sensitiveness to being touched, always worse from excitement and during menstruation. Very frequently bella-

donna is the only remedy which is necessary in the early stages of acute erythematous eczmas, especially of the face, where there is marked reddening with slight puffing of the face, decided heat, marked stinging and itching, and always worse from exposure to the air and from direct heat such as from the sun or fire.

*Erysipelas.*—Belladonna is of especial use in the early stages of erysipelas. The redness is marked, there is puffing of the face, there are the usual belladonna cerebral symptoms, the pain comes and goes—rather suddenly in fact; there is marked fever; vesiculation or bleb formation has not as yet established itself; the patient is always worse from cold and from draughts; cannot bear to have it touched; slightest change of temperature causes the patient extreme annoyance; the application of heat is intolerable. When the puffing of the face, however, is extreme, causing the eyes to close, and other symptoms warrant it, then it is apis 6x, every fifteen minutes in hot water. The results are truly remarkable.

*Erythemas.*—Erythema scarlatinaforme, simplex, multi-forme, nodosum; belladonna is always useful in these types of dermatologic affections during the early stages of these conditions—that is, during the stage of hyperæmia. The erythema is of a bright red or scarlet color, there is the usual marked sensitiveness to touch, there are burning and stinging sensations, and the aggravations always being from draughts of air. Belladonna has as well been of use occasionally in even the later stages of these types of erythema.

*Herpes Zoster.*—Belladonna is of use in those painful types of herpes zoster which are especially sensitive and object to being touched; the clothing coming in contact with the lesions causes extreme pain which, however, is a transitory type—coming and going. The patient cannot bear hot or warm applications, which make the condition decidedly worse. Belladonna is only of use in the early stage, that is, the stage of erythema, with intense pain along the nerve trunk, which tells of the on-coming attack of herpes. When the vesicular stage has arrived you must look to other remedies.

*Rosacea.*—Belladonna is only of use in the first stage of rosacea, that is, the stage of erythema, which is co-associated with marked flushing of the face which is of an intermittent type and the usual sensitiveness to touch. The patients are usually women who are of an excitable temperament and who

are full blooded. The belladonna condition usually comes on at the menopause and is always worse from exposure to the air and to heat.

Belladonna is as well advocated to be of use by some authorities in the second stage of rosacea where there is rapid formation of pustules, especially upon the nose and cheeks. In my own clinical experience, however, I have never been able to verify this condition because belladonna is not of use where there is a decided and permanent congestion—only in the early and transitory stages of erythemas. This point I believe, however, to be disputed by some of our leading therapeutists.

Try belladonna in your dermatologic troubles when indicated and see what a good friend it will be to you and patients alike.

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#### THE HOMŒOPATHIC INDICATIONS FOR THE USE OF BELLADONNA IN DISEASES OF THE INTESTINAL TRACT.

BY

WILLIAM H. YEAGER, M. D., PHILADELPHIA.

THE homœopathic indications for the use of belladonna in diseased conditions of the intestinal tract can be told in comparatively few words. When referring to Hering's Condensed Materia Medica, as well as to Farrington's own book, and also Copperthwaite and Kent, and that excellent work of Clarke, one is struck by the fact that all these writers mention various kinds of *pain* as the *predominating* feature in the symptomatology.

Painful conditions within the abdomen make us think of belladonna, and when this condition is associated with other concomitant symptoms that verify our choice, we can feel very sure of accomplishing much good for our patients, because belladonna is one of the really *dependable* remedies of which we may justly be proud.

I should like to emphasize this matter of pain and tenderness in the abdominal case calling for belladonna. Indeed, I should hesitate to use the drug in cases where some other feature predominated. It seems to me that we can separate these painful cases into *two classes*,—the first embracing those pathological conditions responsible for the various enteralgias,—



and the second those associated with congestion and inflammation of the parts.

Take for example, the abdominal crises of locomotor ataxia. How often that sharp, knife-like pain comes on without a moment's warning, lasting for a variable length of time, and leaving as suddenly as it appeared! Then, too, we can all recall the *intensity* of the patient's sufferings. Again, in cases of gall stone colic, we have an example of intense pain coming very suddenly and leaving in the same fashion. The sudden appearance and disappearance and the intensity of these pains are the qualifying points which make us sure we are dealing with the belladonna patient.

The second class, those due to congestion and inflammation, embraces a great number of cases seen every day in practice. Here we have extreme hypersensitiveness of the parts. The abdominal muscles are very rigid, and the patient dreads even the approach of the examining physician. The slightest jar of the bed causes pain. Fever becomes a feature, and a hot, steamy condition of the skin will be noticed. Congested head, with all the symptoms consequent upon a congested and irritated brain may be present.

Now, I would like to call your attention to the fact that acute pancreatitis, which does not reach the stage of collapse, is often met homœopathically by belladonna or atropin in homœopathic doses. This disease is being recognized nowadays, or at least suspected, and its symptomatology frequently suggests belladonna.

In cases of duodenal ulcer, belladonna may be indicated by the character of the pains, and will, in carefully selected cases, relieve the patient's sufferings, but belladonna will not assist the ulcer to heal because it is not related to ulcerative processes, but only to the stage of congestion and early inflammation. Pathologically, belladonna is not homœopathic in ulcer.

In some of the acute congestions and inflammations of the liver, gall-bladder, and bile-ducts, belladonna frequently does royal work, and here, as in some cases of early appendicitis, the remedy properly used will at times do away with the necessity for an operation. Many abdominal conditions are finally surgical because the *early* prescribing was not scientifically (*i. e.*, homœopathically) related to the symptoms and conditions presented by the patient. Even in peritonitis we can

use our belladonna in suitable cases and very materially assist the surgeon in his endeavors to save a life.

In typhoid fever, belladonna is one of our *early* remedies, indicated at times by abdominal pain and tenderness; and at other times, because of the general symptoms of fever, moist skin, full pulse, flushed face, headache, etc. The head symptoms that occur before the toxemia of the disease is marked, are nearly always congestive and are best met by belladonna. Typhoid fever in children is very often relieved by the use of the remedy.

Colic in young children is a prolific condition for the exhibition of the remedy. There are pinching pains about the navel as if the parts were squeezed or seized with the nails. The abdomen may be distended. The transverse colon may stand out like a pad stretched across the upper abdomen. The child may be suffering with an enteritis. The stools will be thin and green and contain whitish particles like chalk.

Finally, it may be well for us to recall three conditions which are never found in the symptomatology of belladonna, because it is just as important to know *when not to use* these great polychrest remedies of ours as it is to know when to use them.

In the first place, belladonna does not suit chronic diseases except when an acute condition is implanted upon it, and then belladonna only relieves the symptoms that belong to the later acute developments.

Secondly, belladonna does not have a coated tongue in these intestinal cases, nor an offensive breath. There is a marked absence of evidence of any catarrhal process.

Thirdly, there is nothing offensive about the belladonna patient. The sweat is not offensive. The breath is sweet. The bowel movements do not smell badly, and the flatus is odorless.

## BUREAU OF SANITARY SCIENCE

E. G. WHINNA, M. D., Chairman

## WHATSOEVER A MAN SOWETH THAT SHALL HE ALSO REAP.

BY

E. G. WHINNA, M. D.

As the son of a Methodist preacher, it is but natural that I should require a text for my discourse, and the one to which I wish to call your attention to-day will be found in the sixth chapter of Galatians, part of the seventh verse, "Be not deceived, for whatsoever a man soweth, that shall he also reap." This statement of fact is just as true to-day as it was 1900 years ago, and is just as true of the body as it is of the soul.

Science is rapidly achieving the conquest of all germ diseases, while the "habit diseases" due to personal practices and habits are alarmingly on the increase.

Unperverted instincts and natural appetites would prove to be safe and unerring guides in choosing the way of life, but the civilized man, through physical disobedience and artificial living, has grossly perverted his natural instincts, and largely lost his "horse sense."

Some persons have inherited such vast riches of physical wealth that they are able to live a long time as hygienic spend-thrifts with but little personal suffering. The result of their careless living usually appears in the lives of their sickly children. Truly of them it may be said, "The fathers have eaten sour grapes, and the children's teeth are set on edge."

Sanitary science, known also under the name of preventive medicine, state medicine, hygiene and public health, has been defined as an application of the laws of physiology and general pathology to the maintenance of the health and life of communities, and to the prevention of the transmission of the so-called infectious and contagious maladies. The famous Sir Philip Sydney, a great favorite of Queen Elizabeth of England said, "The ingredients of health and long life are—



"Great temperance, open air,  
Easy labor, little care."

But alas! how few of us are so fortunately situated as to be able to follow his directions entirely.

Physicians are supposed to obtain their sustenance from the illness of others, and yet the physician is the only man in the world who devotes his time and energy to combating those very conditions whose existence is supposed to furnish him with a living. With this end in view, the research of every medical laboratory in Europe and America, is directed toward the discovery and eradication of disease causes, rather than to the treatment of diseased conditions.

With the discovery of the origin and spread of disease by germs has come the most radical reforms in public sanitation and the enforcement of laws that will render these discoveries effectual for the benefit of the general public.

If the concerted co-operation of the human race could be secured, it lies entirely within the power and possibility of man to drive all "germ diseases" from the face of the earth.

The Right Hon. Benj. Disraeli, author, statesman and Premier of England in 1868, once said: "Public health is the foundation upon which rests the happiness of the people and the power of the State. Take the most beautiful kingdom, give it intelligent and laborious citizens, prosperous manufacturers, productive agriculture; let arts flourish, let architects cover the land with temples and palaces; in order to defend all these riches, have first rate weapons, and fleets of torpedo boats, yet if the population remain stationary; or if it decreases yearly in vigor and stature, the nation must perish. And that is why I consider that the first duty of a statesman is the care of the public health."

Each advance that has been made in medical knowledge and understanding of the more dreaded diseases of mankind has been marked by improved methods for their control and elimination.

Small pox, typhoid fever, tuberculosis and many other diseases, have been made to feel the check of the scientific methods and regulations of local and national health departments.

The constant increase in the size of cities and the density of urban population is giving rise to new dangers to health, that demand attention and active efforts on the part of physicians

and health boards. The portion of the population which is paying the heaviest penalty for these conditions, is evident from the shocking mortality that exists among the infants and younger children of our cities and towns. The annual deaths that occur among babies under one year of age alone, is nearly double the number of deaths from tuberculosis. An investigation of the infant death rate in one's own city should convince one of the importance and urgency of the problem.

In the United States, all the time, there are three million people seriously sick from preventable causes. Not a minute passes, which does not witness at least one death from preventable disease.

Over one thousand seven hundred unnecessary deaths occur in our midst every day of the year, a daily Titanic disaster, but the more pitiable because preceded by weeks, months, and often years of weary suffering; a wanton sacrifice every year upon the altar of ignorance and apathy of over six hundred thousand victims.

As an economic consideration alone, these figures are alarming; for from a monetary point of view, it is estimated that the preventable loss to the people of our country through sickness and death, is two billion dollars every year, or about twice the gross annual income of the Federal Government.

A minister of the Gospel was once asked why his people were not more aroused to their danger in falling from grace as he placed it before them in his sermons. He said, that they had hell and damnation preached at them so much, that they were calloused and paid no attention to it. They were interested in other matters and attracted to worldly affairs with changing programs. Unfortunately a similar condition exists in our relations to the problems of sanitary science.

We are used to people dying from typhoid fever in far larger numbers than should have the disease at all. We look with the unconcern of familiarity upon the long death list of tuberculosis. We note the ravages of malaria more because the disease has irregularities in its progress than on account of its destructiveness.

And when we are told again and again that these great death dealing diseases are unnecessary and within our control, if we but change our conduct in some slight degree we feel as the congregation did, and let hell and damnation go until another time. One of our most valuable rights and one that we should

cherish most highly, is that of being healthy, and upon the physician largely rests the responsibility for securing and maintaining for us that right. This responsibility is more than a personal matter. To one's right to health must be added the right of the public to require the individual members of a community to be healthy. If one impairs his constitutional well being, the community suffers; the degree of injury sustained by society naturally varying with the individual ailment. The few claim the privilege to act as they please, regardless of the effect on others, but the rights of the many are superior to the privileges of the few.

The first essential principle of one's life should be the preservation of one's health. A person cannot be happy if he is sick, even if he be wealthy, neither can he be unhappy if he is well, even if he be poor. As I have quoted before, the stability of a nation depends upon the health of its people,—primarily on the health of the family unit. For the health of my family is of as vital importance to my neighbor, as is the health of his family to me and mine. If his family is stricken by disease my family will probably suffer in some way directly or indirectly, and thus a serious epidemic may originate from one case of sickness, and spread out into the community, out to the village, out to the country and adjoining towns, and on and on unchecked, unless by a combination of community interests, the whole people unite to prevent the further spread of the disease.

It is clearly evident that general regulations for preventing disease must be made and administered by boards of health, as they alone are given the authority to enforce such measures, but there is much that does not come within their province, that should be done by the family physician. The large majority of people, especially those living outside of the cities, know practically nothing of the principles of sanitation. They do not appreciate the sources or dangers of pollution of water, used for domestic purposes, or the dangers to health that come from impure food. These two subjects of pure water and clean milk would furnish a large field for work for physicians, and when the public can be taught the importance of these two things in connection with health, typhoid fever will practically be a disease of the past, and the tremendous percentage of infant mortality will be decidedly lessened.

Many city people when financial conditions will permit, are



accustomed to spend a portion of the summer season away from home, and this is both natural and salutary, provided good judgment is exercised in the selection of the country place or seaside resort, as regards its general healthfulness and sanitary environment. Unfortunately sanitation on farms and in rural communities is not always what it should be and the result is that many health and pleasure seekers return to their homes in the fall infected with malarial or typhoidal poisons. There was a time not many years ago when typhoid fever seemed to be particularly a disease of the cities.

Then the cities, alarmed at the increasing death rate, improved the sources of their water supply, installed filter systems or other purifying devices and thus achieved at least a partial conquest of the disease. Now the danger zone seems to have shifted from the city to the rural regions; and to-day there are many American cities which would be practically free from typhoid were it not for the cases brought in by persons coming from the country.

Rural health officials should make every effort to combat the disease, paying special attention to the pollution of streams, the milk supply, and unsanitary conditions about farm houses and out-buildings. Dairy men should be especially careful in observing precautions of cleanliness as instances of typhoid epidemics in the country conveyed through the medium of milk, have been frequently reported of late.

More than a score of typhoid cases in the Chester Valley were traced to milk from a single dairy farm where there were three victims of the disease.

By prophylaxis we mean the art of preserving from or preventing disease or the observance of rules necessary for the preservation of health. Prophylaxis in general includes national, state and municipal assistance, together with earnest concerted efforts of medical societies; care, caution and energetic attention of physicians, and an intelligent understanding and careful observation of necessary precautions by the public.

Sanitary laws and regulations are a necessity in preventing disease and they should be of sufficient scope to cover all sources of danger and so practical as to be capable of being enforced. It is amazing how intelligent people will disregard and try to evade the quarantine regulations of the health officers.

The time has certainly come when civilized nations must take

up the question of contagious diseases seriously, as the sanitary regulations are for the benefit of the community as well as for the individual. Judicious quarantine laws, intelligently applied tend to the efficiency and well being of a nation, and it is no exaggeration to say that the most needful thing for the continued progress of mankind is the proper administration of sanitary science.

Without it great cities, like Sodom and Gomorrah of old punished for their sins, have perished almost in a night. For lack of it, cholera unleashed upon the banks of the Ganges by the pilgrims, whose freight, rags and bedding have become contaminated by infected discharges, has circled the globe in a few short weeks. Without it, the plague stricken rat has clambered aboard ships lying at the wharves of infected cities, over the unprotected gangways and hawsers, crept into the dark holds of vessels, and has thus been carried along the highways of commerce from port to port, leaving recurring foci of infection in every clime of the world.

Preventive medicine has established measures for preserving the public health that may be annoying to individuals, and consequently cause unpleasantness between the physician and his patients or their friends, nevertheless the duty of the physician is to the public as well as to the individual even though the individual should be offended, and the physician incur widespread criticism and disfavor by enforcing sanitary regulations that save hundreds of lives and prevent untold suffering, but which may cause some individual inconvenience.

The advancement achieved by sanitary science in the past few decades has been enormous, and without exception the diseases in which a reduction of mortality has been effected belong to the contagious or infectious type. This is significant for the work of the health boards has been almost entirely along this line, and it proves beyond doubt the efficiency of cleanliness. Note the marvelous changes that have been wrought in Cuba, the Philippines, and in the Canal Zone.

In reference to conditions on the Isthmus of Panama, Dr. Howard King of the Tulane University School of Tropical Medicine, believes it is none too early to consider the dangers to the public health that may follow the opening of the Panama Canal, and to guard against them. He suggests that our Government assign experts to assist South American nations

in organizing an effective public health service, backed up by needed legislation.

The justification for this sort of paternalism with regard to our careless and often ignorant neighbors, is that it is for our own protection.

The canal, indeed, will render them almost next door neighbors. Colombia, Peru and Chili are strangers to modern methods of hygiene.

They regard yellow fever as an unavoidable visitation. The so-called dirt diseases they have always had with them, and it has never occurred to these governments to take steps for their elimination. Ecuador recently requested the services of Col. Gorgas in cleaning up Guayaquil, thus setting an example to the others and indicating that South American countries would welcome aid from outside in setting their houses in order.

Colonel Gorgas's wonderful accomplishments in the Canal Zone by simple and efficient application of the principles of preventive medicine which have been slowly learned in the past twenty years, is the achievement of the most practical interest to all mankind as it opens up a country considered almost uninhabitable, to the occupancy of people of all climes. In demonstrating the truth of our gradually acquired theories of preventive medicine, it makes possible the opening up of vast areas of civilized enterprise.

That these achievements should finally be brought to their culmination by American physicians or men working under American support should be a matter of national pride and congratulation.

So much the splendid advance in preventive medicine has given us, but let us not mistake the fragment we possess, for the totality to which it is destined to grow.

Let us each do our part, and filled with high aspirations; take up the work with greater zeal than ever before; co-operate intelligently with the health authorities in the gigantic struggle which is now being waged in the arena of hygiene by the trained forces of science, against the malignant forces of disease; in this great health battle which is now on, having for its object the prevention of disease, the promotion of health, and the preservation of the race, and then when we come to the end of the way we can say in the words of Eugene Field:

Happy the man that, when his day is done,



Lies down to sleep with nothing of regret.  
The battle he has fought may not be won,  
The fame he sought be just as fleeting yet;  
Folding at last his hands upon his breast,  
Happy is he if, hoary and forespent,  
He sinks into the last eternal rest,  
Breathing these only words, "I am content."

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ETIOLOGY OF MALIGNANT GROWTHS.—G. Leopold's article on malignant tumors from injection of pure culture of blastomycetes, and malignant tumors in animals after implantation of human carcinoma comprises the concluding work of this author who has been occupied with this subject for many years. By means of these injections Leopold has been able to cause the growth in rats of tumors from which he was able to culture blastomycetes. He has been successful therefore in demonstrating these micro-organisms, to grow them artificially, to produce tumors ultimately destroying the animal, and from them to grow again the micro-organisms. As has been pointed out, however, he has not been successful in complying with Lubarsch's suggestion which would show the etiological relation between the parasite and the neoplasm, namely, to produce the neoplasms, by means of the micro-organisms, in the same animal species. A number of well executed photographs and other illustrations grace this scientific contribution, which together with Leopold's other work in the same line must be regarded as most valuable.—*Arch. f. Gyn.*, Vol. 96, 405.

**THE DIAGNOSIS OF ERUPTIVE DISEASES OF THE MOUTH AND THROAT.**

BY

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THE mucous membrane of the upper respiratory tract presents characteristic clinical pictures during the course of the acute contagious and specific diseases, the acute intoxications, constitutional derangements and disorders of the digestive, respiratory and circulatory systems. Frequently they afford the only objective signs; at times offer corroborative evidence; again, as in measles, permit of an early diagnosis and the changes are always of such considerable importance that no examination is complete until the buccal nasal and laryngeal cavities have been inspected. Pediatricists have for many years realized the necessity of carefully looking, as a routine procedure, for lesions in the nose and throat. It is just as essential to thoroughly search for abnormal conditions in adults.

In attempting to describe accurately the clinical picture of any disease as found on mucous surfaces we must first of all remember that the anatomical difference between mucous membrane and skin and the macerating effect of saliva and moist secretions alters the appearance of the primary lesion very quickly. We can illustrate very well these differences in a comparative study of the eruption of smallpox on the skin and mucous membrane. On both macule and papule evolve with just about the same rapidity, but on the buccal surface the vesicular stage is of short duration and during the pustular stage the mouth presents ulcerations but slightly elevated above the surface.

For clinically important considerations we will compare eruptions calling for a differential diagnosis without regard to any dermatological classification.

Vesicular eruptions develop chiefly in herpes zoster, herpes febrilis, from reflex causes, in pemphigus, in erythema-multiforma, urticaria and in toxic erythema. Herpes zoster developing only along nerve branches supplying mucous membrane is rarely encountered, though several cases have been reported. Herpes febrilis accompanying pneumonia, influenza, rheumatism, and even a simple cold is of frequent occurrence, develop-

ing at the junction of skin and mucous membrane on the lining of the cheeks, the soft palate, the tonsils, posterior wall of pharynx and rarely on the epiglottis and introitis laryngis. This variety is never disseminated, the efflorescence assuming a group formation. The primary vesicle is seldom seen for reasons already given, it lasting, as a rule, not more than a half hour, when the epithelial layer is thrown off as necrotic tissue and the base of the small round ulceration is covered after a short time with a fibrous exudate. The vesicles in each group are all alike, develop, run their course and disappear at the same time. On the pharynx they are frequently recognized as small punched out spots. It is quite possible to find groups of vesicles developing one after another. It is important to recognize such an eruption because local treatment is absolutely contraindicated, all applications causing intense pain. Rarely they may develop in such close proximity that the fibrous deposits simulate diphtheria. Herpes developing in the mouth as a manifestation of reflex irritation has been observed during the menstrual period in a large number of cases.

The eruption of pemphigus and erythema multiforma can be differentiated with little difficulty. Acute pemphigus is seldom observed, the chronic variety often. In both diseases vesicles are found if frequent examinations are made, those of pemphigus varying in size from a pin head to a large pea, at first transparent then cloudy; after a short time rupture occurring, associated with a loss of substance which becomes covered in turn by a thin fibrous exudate. The characteristic lesion of erythema multiformae is a dark red macule, discrete or confluent, occurring primarily on the soft palate and uvula, the vesicle being seldom observed. In erythema, pain is exquisite; there is little salivation, the eruption is accompanied by severe inflammation, but the lesions do not enlarge peripherally, bleeding may be severe. In pemphigus, pain is not so prominent, but salivation is marked. There is very little inflammatory reaction, the lesions extend peripherally, have a serpiginous outline and there is little tendency to bleeding. Contrary to the eruption of erythema multiforma there is also healing centrally as the peripheral progression proceeds. The method of extension on the mucous membrane corresponds closely to the epidermolysis observed on cutaneous surfaces and is pathognomonic in both locations.

It is important to recognize pemphigus because not infre-



quently this disease appears first in the mouth, developing secondarily on the surface of the body. Indeed, the eruption may be confined to the upper respiratory tract. Pemphigus vegetans almost invariably appears first in the mouth.

Urticaria develops usually as small or large blebs on the uvula, tonsils and tongue. The œdema occasioned may be sufficient to produce respiratory embarrassment. It is differentiated from erythema multiformæ by the red, slightly elevated macules of the latter.

The differentiation of lichen ruber planus and leukoplakia and frequently of the specific and non-specific varieties of the latter can usually be definitely made. Lichen ruber planus occurs as a primary affection or may be secondary to the skin eruption. On the mucous membrane it is found as small white polygonal or half spherical nodules, blue white, rather hard, arranged in lines or disseminated, the edges rising sharply, almost at a right angle from the surface, beginning with no sign of inflammation, is found usually in the vestibule of the mouth extending forward to the skin of the lips and posteriorly to the palatine folds. At times the tongue is involved, appearing as though coated with silvery white plaques. Just as on the skin, vesicles may, though rarely, form in the mouth, producing erosions which may be so deep that they bleed.

Leukoplakia, luetic in origin, begins as small red spots, on the base of which soft thickenings develop with signs of inflammation, developing on cheeks and tongue, frequently as a primary pigmentation, connective tissue hyperplasia appearing later. The color resembles mother of pearl, the boundary is not so sharply defined as in lichen planus, although when fully developed there are no inflammatory signs. On the tongue these spots appear somewhat depressed, the pearly surface is lacking, and they are recognized only by their smooth surface and the light red coloring of the surrounding tissue. Smokers' leukoplakia develops with no inflammatory reaction, consists of polygonal thickenings not arranged as in lichen planus and is more apt to be bluish white and more sharply outlined than the luetic variety.

Geographical tongue and the fissured tongue of syphilis will not be confused if we recall that in the former the bottom of the fissure has normal papillae, in the latter the bottom of the fissure is a scar.

Stomatitis and the mucous plaques of secondary syphilis

may be appropriately compared, for in the mouth they are frequently confused. Both begin in the same way; sharp edges and reaction in surrounding tissue, after one or two days, however, the diagnosis is easy, the apthous patch does not extend peripherally and on its surface is necrotic tissue which is cast off en masse, leaving a regular sharply outlined ulceration with hyperæmic zone. It is never confluent. The mucous patch, histologically, is an epithelial thickening surrounded by an area of round cell infiltration, appears gray or bluish gray, at times almost transparent, looking not unlike a spot recently touched with a solution of silver nitrate and surrounded by a hyperæmic zone. In this stage we find the resemblance to the apthous patch. They appear on the cheeks, tongue, tonsils, palatine arches, uvula and seldom in the nose and on the pharynx. Soon the thickened epithelium in the centre is thrown off, leaving an excoriation, about this is a layer of thickened epithelium appearing as a gray ring, and beyond this a third zone of acute hyperæmia, three concentric rings. By the concentric extension and coalescence of a number of patches, we may find a large confluent area. It is well never to cauterize a suspicious spot.

The recognition of mucous patches not infrequently affords the only means of making a correct diagnosis. I have seen one case in which the diagnosis was made by the ulceration on the vocal cords alone. Ulcerations on the cords may be either luetic or simple catarrhal abrasions as in acute laryngitis from contact. Secondary specific ulcerations on the cords do not cause infiltration, but their location will vary from day to day; if due to a laryngitis they are always found in the same place.

Syphilis in the upper respiratory tract offers such an endless subject for discussion that we only give a few clinical rules.

Any hard infiltration of the tonsils is always either a chancre or cancer—both have adenopathy. Late specific ulcerations are always deep, sharply defined and are always accompanied by active inflammatory reaction. In the pharynx and larynx, local treatment of syphilis is not necessary. In the nose intelligent local treatment is imperative, the early hyperæmia of syphilis is characterized by its sharp outline, a catarrhal inflammation fading gradually into surrounding tissue.

Lupus and tuberculosis of the mucous membrane are important subjects, but we shall give only a few points to aid in their clinical diagnosis.

In lupus the primary eruption may appear in the nose or mouth. The lupus papule is never brown, as on the skin—is always red. In lupus the uvula is thickened, the soft palate is studded with small uneven nearly circular, round elevations sharply outlined, all alike, same size, etc. They may occur only on the soft palate, only on the palato glossal fold or uvula. Sometimes a small vesicle develops on top of the papule and a small white necrotic spot appears; the course is very slow, lasting for years. It develops usually from the nose, traveling along the floor to the posterior surface of the soft palate—almost never perforates, although we may see shallow ulcerations. Lupus may extend from the nose to the skin, traveling without perforating directly through the soft palate instead of round and up the anterior aspect. In all cases where the soft palate seems infiltrated you can realize how essential is a post-nasal examination.

Brown spots on the lips and soft palate sharply outlined may be nævi. Many nævi develop or appear at puberty, not necessarily at birth.

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### AN INTERESTING CASE OF MASTOIDITIS.

BY

GILBERT J. PALEN, M. D., PHILADELPHIA.

THE case which I shall cite is interesting because of coincident conditions which obscured the real trouble. It is at the same time a case which points out the necessity for thorough examination of a case when unusual symptoms arise, and it furthermore brings out one or two points in diagnosis of value to the general practitioner.

The patient, James T., age 28 years, three weeks prior to his visit to me had developed pain in the left ear. This rapidly followed by a great swelling over the mastoid. This pain was greatly increased by chewing, by traction upon the auricle or any touch of the auricle. He had following this attack a very slight discharge. When he came to me he was complaining of the same character of pain in the left ear. The auricle was very prominent; there was marked cedema over the mastoid, and the auricle was swollen. The drum could not be seen be-



cause of complete closure of the external auditory canal. There was intense tenderness anterior to the auricle.

The prominence of the auricle and post-auricular œdema were, of course, suggestive of mastoiditis (I have had many cases referred to me for mastoid operation because of these objective signs), but against this diagnosis we had the character of the pain which was increased by traction on the auricle, by motions of the jaw as in chewing, and again, careful palpation of the mastoid, avoiding any movement of the auricle, proved a marked absence of tenderness in this region. Furthermore, there was no history of a preceding middle ear condition which is usual in mastoiditis. This case became progressively worse during the next few days, when he had a sharp rise in temperature with some chilliness. This rise in temperature, on account of the existing local condition, would have been misleading had we not followed our usual custom of making a thorough general examination of the patient. We found the cause of the temperature rise to be a tonsilitis. During the next three days the patient gradually improved, the tonsilitis subsiding and the condition of the external canal lessening somewhat. He then developed excessive pain in the mastoid region with now undoubted tenderness and slight discharge from the external canal. The sensitiveness of the auricle and pain on chewing still, however, remaining. Examination of the post-nasal space showed intense congestion. Four days later the mastoid tenderness not lessening, and the œdema increasing the patient was operated. The antrum and the tip cells were found full of pus. For two days after the operation there was marked improvement. He then developed intense pain in the head and nape of the neck and was extremely tender in this region. In addition to this his entire scalp became œdematous. Ankle clonus was present on the left side. The next day this was found present on both sides. He complained of an intense, splitting headache of the meningeal type. The œdema of the scalp was very marked. As we had found suggestive lesions along the spine we questioned him closely, and finally he admitted having had chancre three months before, followed by sore throat and other secondary symptoms. We then gave him specific treatment which controlled almost immediately the intense headache. Three or four days later suppuration of the scalp started and the case from that time pursued a normal course to recovery.

A THEORY OF SIMILIA SIMILIBUS CURANTUR SUBMITTED TO THINKING  
AND SCIENTIFIC HOMŒOPATHISTS.

BY

JOSEPH C. GUERNSEY, A. M., M. D., PHILADELPHIA.

*(Continued from the HAHNEMANNIAN MONTHLY, January, 1913.)*

WHAT law or laws cause and control the precept *Similia Similibus Curantur*? In the January issue of this journal I suggested as an answer to the above, "equal forces acting against each other in contrary directions mutually destroy each other's effects." (Tristram Shandy). Also, I published letters from a few of our eminent colleagues with whom I had corresponded upon the subject.

I here add a few more letters of the same purport. The theme is a fruitful one and the editor of the HAHNEMANNIAN MONTHLY will be glad to receive and publish further essays bearing upon this topic.

Saturday, April 27, 1912.

DEAR DOCTOR GUERNSEY:

Your letter with enclosed remarks upon "*similia similibus curentur*" reached me Thursday. I have read them with interest. Your quotation from "Tristram Shandy" is quite *a propos* and no doubt was suggested by that well known law in physics that two equal forces coming together from opposite directions neutralize one another—or, as we used to express it, "the force required to destroy motion in one direction is equal to that required to produce as much motion in the opposite direction."

Dr. Hering, in his lectures used to illustrate by the two tide waves on the coast of Norway which, at certain seasons, reach a height of thirty feet, the one coming from the North Sea and the other from the Atlantic, yet at the point of meeting there is no perceptible tide. A similar phenomenon occurs, I believe, on the coast of Cochin, China. I employed these and other illustrations of like character when lecturing on Institutes. I have no doubt you could elaborate the thought and make an interesting essay.

I fear most of our English readers of the *Organon* miss some of Hahnemann's thoughts by not reading text with context as presented by him in the original. Thus, while from the sections referred to he leaves the matter of intensity of drug force open to question you will find his real meaning in section 33, where he says: "In accordance with all experience it undoubtedly follows that the living human organism is far more disposed to be affected and its health perverted by medicinal powers, than from disease influences and contagious miasms; or, in other words, that the disease exciting causes possess a subordinate and conditioned, oft extremely conditioned power, while the drug forces possess an absolute, unconditioned greatly superior power to morbidly disturb the human health." Again, in section 32 he says: "The conditions are quite different with the artificial morbidic powers (or forces) that we call medicines. Every real medicine acts at all times, under all circumstances, and on every living person exciting in him its own peculiar symptoms (clearly manifest to the senses if the dose has been large enough) so that every living human organism is at all times and absolutely (unconditionally) affected and infected by the medicinal disease, which, as already said (see section 30 and section 31) is not at all the case with natural diseases."

My dear Doctor, I have purposely made the *translations* from the fifth edition of the *Organon* that I might retain Hahnemann's mode of expression in presenting his views, rather than to present those views in a too refined and smoothly reading English.

You will see from them, from what standpoint Hahnemann considered drug power stronger than the causative factors of disease. He also says, in section 34, that it is not the *greater degree of potential energy* that enables medicines to cure, but that *similitude of effect* is the essential—and in section 155 he refers to the fact that "homœopathic cures are effected *without any degree of suffering*"; the reason for which, he says, "is, that the homœopathic remedy employed must be given in such minute dose that it is too weak to develop any of its effects upon those portions of the body that are free from disease." See also section 160.

Hahnemann means that drugs have a greater potential energy, which energy can be employed in dosage just sufficient to equal and neutralize the morbidic agency against which it is directed.



Thus with the law of similar for our guide and with the appropriately small dose we may accomplish Hahnemann's "Ideal of healing" in a "speedy, mild and permanent manner" by the "most reliable and safest means in accordance with plain and intelligent principles." Your brief article is very interesting, and I must thank you for the courtesy of sending it for my perusal.

Sincerely and fraternally,

KORNDORFER.

BRYN ATHYN, PA., May 17, 1912.

DEAR DOCTOR GUERNSEY:

I have read with interest your brief suggestion for a theory of homœopathy. It seems to me to be essentially that of Mr. Howard, which is that the tremulations of the remedy counteract and destroy the tremulations of the disease. Mr. Howard likens this action to the destroying of a musical vibration by the introduction of similar vibration "of an opposite phrase."

My question as to both these suggestions, is, "How do you know that the tremulations of the remedy are in the opposite phrase to those of the disease?"

You will have noted that my notion is that the cure is not effected by the remedy, but that the remedy stirs the vital force to activity in similar fashion to the tremulation of the disease, only more potently, and so with greater reaction of the vital force. This I would harmonize with Hahnemann's theory by suggesting that he does not mean that the artificial disease produced by the remedy, is stronger than the similar disease, and so destroys the disease directly by its own activity, but simply that the artificial drug disease, being more incisive, more strongly rouses the vital force,—which, as I see it, must after all do the work of cure,—to the work of overcoming the disease.

Sincerely yours,

WM. H. ALDEN.

PHILADELPHIA, April 29, 1912.

DEAR DOCTOR GUERNSEY:

I have attentively considered your statements concerning the theory of Similia and would say that I am unable to accept the new explanation. The idea of opposing forces by other

forces in contrary directions is not very new and is the most *obvious* method of overcoming objectionable energies. It spells disaster, however, not alone to the two opposing forces that are immediately concerned, but to the surrounding environment as well.

A coarse illustration may be found in the attempt at controlling a runaway locomotive. An engine with steam up is standing on a siding unattended, when a leaky throttle allows steam to enter the cylinders, the vital parts of the moving mechanism, and immediately the machine proceeds to run away. The common way of stopping it is to pile obstacles, old cars and the like, upon the track for the engine to plunge into which it proceeds to do, smashing these and itself, besides destroying surrounding property and taking life. A better way is to clear the track, allowing free passage, and chase it with another engine in the same direction when it can be brought to a standstill without injury to anything. These two methods have been put into actual practice with results as above indicated. When a horse runs away, the man who jumps in front of the horse with a view of stopping him, by opposing him, invariably fails and, withal, gets knocked down and trampled. Whereas, the man who *runs with* the horse and keeping *along with* him, grabs the bridle, stops him successfully and does not get hurt.

I do not at this time think of any more mechanical illustrations that would be any more apt than those already given, but they exist

The homœopathic principle may be considered due to a series of *interferences* going in the *same direction*.

When you strike a tuning-fork and hold it up in the air its sound is very feeble because both of the prongs are vibrating in the *same* way and the air-waves are going in the *same* direction. It is a case of interference where the condensation-section of one wave fits into the rarefaction-section of the other wave and almost complete silence is the result. If, while the fork is vibrating, a small paper cylinder be slipped over one prong of the fork, the other prong will vibrate much more freely and the sound will be louder.

If a tuning-fork be held over a deep jar and water be poured into the jar until the depth of the jar *above* the water be half a wave length of the musical note that is made by the fork, when the fork is vibrated over the jar the jar will reinforce the wave to such a degree that it will fairly *roar*. If, now, the fork be

slightly turned so as to present one of the edges of the steel strip of which the fork is composed to the depth of the jar, the waves from the two prongs will *interfere* with each other and silence will succeed the roar.

There are *four* positions of the fork where the sound will be tremendously reinforced and *four* positions where it will be weakened almost unto silence. Thus, by slowly rotating the fork over the jar alternations of loudness and silence may be obtained to the number of eight times. When *two* jars are used, *each* being of a depth of *half a wave length* of a given tuning-fork, on vibrating the fork and holding it over *one* of the jars the sound will be tremendously increased. No one can imagine what this phenomenon is like until he has tried the experiment. Now, while this action is taking place, if the other jar be held at right angles to the first, no matter how loudly the first jar is responding, the other jar will cause silence; yet if the prongs of the fork are examined they will be found to be vibrating actively. Remove the second jar and the first will again respond loudly, on the *same* impulse given to the fork. Whatever in the way of disease attack the human system, notwithstanding it may be due to a germ, the phenomenon may be considered to owe its effects to a series of impulses or vibrations. When the similar remedy or simillimum is applied it causes an interference in the *same* direction under the *same* aspect and at the same rate. The hump of one wave fits into the hollow of another and thus vibration is stopped and *silence* or *amelioration* is brought about. Exactly like the tuning-fork and the two jars.

A perfect simillimum, one in which *all* the symptoms are similar to the "sick condition" presents  
a parallel, thus

.....	Disease.
.....	Simillimum.

If the simillimum be imperfect these  
lines diverge, thus

.....	Sick.
.....	Similar.



When the remedy is flagrantly *away* from the simillimum called for, then the lines become wider apart, thus

Sick.

Similar?

When the remedy has no relation to the simillimum called for the lines are like this

Sick.

Non-similar.

And when the remedy is a contrary, then the lines are like this.

Sick.

Contrary.

Yours fraternally,

WALTER M. JAMES.

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APPENDICITIS FOLLOWING SALPINGITIS.—Moritz (Freiburg) says the relationship between these two diseases has not yet been clearly established. Neither can it be determined from clinical observation. The close proximity of the two organs involved and the frequent localization of purely functional disturbances either in the bowels or due to a general nervous cause produce a complicated picture which cannot be clinically differentiated. Neither during operation is the question determinable, but only from histological studies. Schridde has been able to show, contrary to the views held by some gynecologists that appendicitis followed by pyosalping is quite rare. Not one among 280 cases examined arose in this manner. Inflammation may spread in this direction, but it involves the surface and muscular layers of the tube. The authoress has examined 44 cases in whom both organs were removed by operation. Fourteen cases were suitable for the study of the question; two of the cases were tubercular and twelve were gonorrhoeal. In these cases the appendix always showed the same histological changes, namely, intact mucosa, submucosa and inner muscular layer and the absence of primary peritoneal inflammation, but there were localized collections of small celled perivascular infiltration. These changes existing with chronic salpingitis are regarded as characteristic of inflammation advancing from the tube to the appendix, and they were present in 52 per cent. of the cases.—*Zeitschr. f. G. W. G.*, Vol. 70—404.

## EDITORIAL

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### THE DEFEAT OF THE MEDICAL PROFESSION IN ENGLAND.

FROM time to time we have referred editorially to the contest which has been carried on by the medical profession in England with the Government to secure adequate compensation for medical services under the new Insurance Act. After various conferences and arguments, the Government refused to yield to the demands of the profession and an effort was made on the part of the British Medical Association to induce all medical practitioners to sign a pledge refusing to serve under the provisions of the Act.

About twenty-three thousand of the twenty-eight thousand medical practitioners in England bound themselves by a signed pledge to refuse to serve under the Act until its provisions were modified in such a way as to be acceptable to the members of the Association. When the time arrived for the provisions of the Act to be put in force, the physicians who had not signed the pledge at once applied for positions under the Government and those who had signed the pledge, seeing nothing but professional and economic ruin ahead of them, began in large numbers to disregard the pledge and to apply for positions under the Government. Once the break began, it was merely a question of who would be the first to "get in the hand-wagon," and the fight planned by the Association has been turned into a rout. In order "to save the face" of those members of the profession whose honor prevented them from disregarding the solemn pledge they had entered into, the representatives from the various medical societies met on January 18th and formally released the members of the profession from further adherence to the pledge. Thus the contest between the profession and the Government for the purpose of securing fair treatment and adequate compensation, has resulted in utter defeat as far as the medical profession is concerned.

Viewing the matter from the standpoint of an outsider, it is difficult to see how the vast majority of the medical practi-

tioners in England will be able to continue in medical work now that the Act has been put in force. Under its provisions, free medical attention is provided for all persons whose earning capacity is less than eight hundred dollars a year, which would be equivalent to one thousand or twelve hundred dollars a year in the United States.

The effect upon the medical practice is already evident. For example, Sir J. de Rees cited the instance of a practice in Middlesex worth seventy-five hundred dollars before the passing of the National Insurance Act which is now unsalable. He also referred to another practice for which six thousand dollars were offered before the Insurance Act was in sight, and which realized forty-nine hundred dollars after it was passed, and now it cannot be sold at any price.

There is considerable complaint that many members of the profession who have accepted service under the Government, have disregarded all professional precedent and are issuing circulars and informing insured persons that they are on the panel and are open to accept names on their list. These circulars are being distributed broadcast and, in addition, many practitioners are endeavoring to secure the influence of officials of the Insurance Societies in order that their persuasive efforts may be brought to bear upon the insured persons to select them as their doctor. The Association is endeavoring to repress such practices, but so far, so great is the economic strain in the face of almost ruinous conditions, that all of the previously existing rules of professional conduct have been disregarded by the vast majority of medical practitioners.

Although the Act has only been in force for a few weeks, its disadvantages to the profession and to the public are already in evidence. For example, in the *London Times* of January 21st, an account is given of a patient suffering from abdominal pain who applied to one of the Government physicians for treatment. The doctor, thinking the case was a simple one gave the patient a prescription which did not relieve him. A day or two later the patient died and an autopsy showed femoral hernia which had become gangrenous. At the Coroner's inquest it was testified by competent physicians that, had an examination been made, and an operation performed, the man's life would have been saved. In defense the physician testified that it was practically impossible to examine patients properly and do the work required of him by



the law. He stated that, on the day that he was consulted by the deceased, he was engaged for *six hours* at a stretch *signing cards*, which he was compelled to do under the Act for persons desiring treatment, and that, not infrequently, there was a *crowd of two or three hundred persons* waiting with cards to be signed before they could secure treatment. In such circumstances it was impossible to properly prescribe, much less properly examine patients applying to him for treatment. The Coroner's Jury, after deliberating over the case, returned a verdict of death from natural causes and excused the physician "*owing to the scandalous amount of work that was imposed upon him under the Act.*"

From these and other facts that have developed during the past few weeks, it is evident that the National Insurance Act in addition to proving ruinous to the medical profession, is likely to prove harmful to the public as well, and that sooner or later the Government will be compelled to recognize that the laborer is worthy of his hire, and that competent medical service can only be secured by the payment of adequate fees.

We cannot close this subject without calling attention to the utter lack of efficient organization that exists among the medical profession. Had the Government been engaged in a contest with hod carriers or coal heavers instead of physicians it is probable that they would have stuck together and that the Government would have been compelled to grant all or part of their just demands. Over the medical profession, however, the Government won an easy victory and, despite the numerous theoretical objections that can be raised to so-called trade unionism, the experience of the medical profession in Great Britain has demonstrated the fact that it is only by effective organization that the profession can hope to secure or to retain its just dues.

G. H. W.

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#### THE MOST COMMONLY USED DRUGS.

THE investigation that has been carried on by Professor John Uri Lloyd in order to ascertain what drugs are used by the largest number of practising physicians has revealed some very interesting and instructive facts.

Professor Lloyd first wrote to a number of old school physicians and secured from them lists of the vegetable drugs they

used most frequently. Echinacea headed the list, having received the approval of one hundred and forty-eight physicians. Next came aconite with one hundred and eight votes, then cimicifuga with ninety-six, followed by bryonia, gelsemium, pulsatilla, veratrum, belladonna and cactus in order as named. In all one hundred and seventeen plant remedies were listed. He then made a canvass of the eclectic physicians who gave their preference for gelsemium, aconite, bryonia, cimicifuga and echinacea.

There being some question as to whether these lists could be considered representative of the practice of American physicians, lists were made of all vegetable drugs utilized by physicians whether regular, eclectic or homœopathic. These were sent to thirty thousand physicians in every part of the United States. All were graduates of well established colleges. Ten thousand replies were received and it is probable that the results give a very general view of medicinal plants that are actually employed by American medical men. It is remarkable to note that cactus received the greatest number of votes (6,239), hydrastis came next, followed in the order mentioned, by aconite, gelsemium, ipecac, digitalis, ergot, belladonna, nux vomica and hyoscyamus. Echinacea received 5,065 votes; thuja stood fifteenth on the list, opium sixteenth, bryonia eighteenth, pulsatilla twenty-second, hamamelis twenty-seventh and cinchona thirty-seventh.

As a result of his investigation Professor Lloyd concludes: "That the majority of physicians are guided in their uses of remedies by their own judgment based upon clinical observation and professional necessity. It is evident that physicians in actual practice generally prescribe as they see fit regardless of whether a drug or preparation is mentioned in the pharmacopeia or has been recommended by their therapeutic instructors or whether it would be advocated or not by the leaders now in authoritative positions."

One cannot read this list without being impressed with the fact that many of the drugs that have received the highest number of votes from practical physicians, have been pronounced absolutely inert by pharmacologists who base their opinions as to the therapeutic value of drugs purely upon animal experimentation. For example, cactus, which received the approval of more physicians than any other vegetable remedy, was only very recently condemned as utterly useless

by a committee of the American Medical Association. The same committee also pronounced echinacea an inert drug, and only recently, a prominent old school pharmacologist has declared that aconite possesses little or no therapeutic value. To the homœopathic practitioner it will be pleasing to observe that by far the larger proportion of the vegetable remedies that have received the most general approval of physicians of all schools have been those whose therapeutic properties have largely been developed and defined by homœopathic physicians.

In basing any conclusions upon this list, however, it must be borne in mind that all synthetic preparations, as well as all drugs derived from mineral sources, have been excluded. So also have the proprietary preparations which we surmise would occupy a very prominent place in the list if complete and authentic reports were obtainable. G. H. W.

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MORPHIA AND HYOSCINE BEFORE ETHERIZATION.—In an excellent article on the preparation of the patient before operation, Grad (New York) treats the whole subject in a most satisfactory manner and one cannot help but endorse his clear and explicit directions. His remarks about avoiding operation catharsis unless definitely indicated, and that patients not purged before operation have less trouble afterwards, are quite within the experience of most operators. He advocates the administration of 1-100 gr. of hyoscine hydrobromide and 1-4 gr. morphine. Hydrobromide hypodermically about one and a half hours before the operation. The room is then darkened and nothing is done to disturb the patient so as to encourage a condition of drowsiness. Such patients are usually calm, do not struggle and have no fear of the anæsthetic, and many do not remember afterward when the anæsthetic was begun. It is important, however, to remember that these patients may have respiratory disturbances if the anæsthetic is crowded too much. The author summarizes the beneficial effects by saying that the fear of the operation and of the anæsthetic is abolished, she is in a state of calmness and mental peace and mental shock is abated. The course of anæsthesia is less excitable. Excessive mucous secretion is absent; salivation is diminished, the fauces are dry, the pulmonary tract having less mucous secretion, there is less likelihood of pulmonary complications.

The necessary amount of anæsthetic is materially lessened. Nausea and vomiting are greatly reduced; 38% have no vomiting or nausea. After operation the patient sleeps quietly and awakens with little recollection of her ordeal. The acute pain incidental to the incision is also avoided.—*Amer. Jr. Obs.* Vol. 65-404.



## GLEANINGS

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NEW METHODS OF DIAGNOSIS OF PATHOLOGIC CONDITIONS OF THE LIVER.—Of the various tests for liver function the author describes the following: "*Ehrlich's aldehyde test*," or the "urobilinogen test." A stock solution is made with para-di-methyl-aminobenzaldehyde, 4 gm., or 2 per cent; hydrochloric acid, 40 gm., or 20 per cent; water and a few drops of alcohol to 200 cc. One or two drops of this solution are added to 5 cc. of fresh urine. In the presence of urobilinogen there develops, usually in the first few minutes, a rose-red color. Exceptionally, the extreme depth of color is not reached until one-half to two hours have elapsed. The reaction is somewhat more common in dark than in light colored urines. In a dark, bile-laden urine, bile pigments obscure the test. The urine with the reagent is then shaken with a few drops of chloroform, when the red color appears in the chloroform at the bottom of the test-tube.

Urobilinogen in the urine must appear from two causes:

1. Impaired liver cells, which have failed to stop, or transform the urobilinogen coming to them through the portal vein from the bowels and which allow its entrance into the general circulation.

2. Congestive circulatory influences, by which the urobilinogen laden blood normally passing through the liver is deflected into the collateral circulation of the portal system—as through the hemorrhoidal veins to the iliac veins in constipation, or to the general circulation through a *caput medusae* in advanced hepatic cirrhosis.

Animal experimentation shows the following changes in the urobilinogen content of the urine when the common bile duct is tied in the dog:

1. On the first day urobilinogen appears in the urine.
2. On the second day the conjunctivae are icteric, and urobilinogen and bile are found in urine.
3. On the third day the dog is totally yellow; bile is abundant in the urine, but the urobilinogen is greatly diminished.
4. On the fourth day the urine is loaded with bile, but contains no urobilinogen.

*Urobilinogen in the Healthy.*—Animal experimentation and clinical experience lead to the acceptance of the following facts:

1. Normal liver cells never let an appreciable quantity of urobilinogen pass into the blood of the general circulation.

2. A very slight loss of normal liver function, even in a part of the liver, is followed by the appearance of a pathologic amount of urobilinogen in the urine. The test is a very delicate one and is not a measure of the gravity of the pathologic condition, but it enables one to answer whether or not the liver is functioning in an absolutely normal manner.

3. Urines from healthy individuals often give a slight pinkish reac-

tion, which is not pathologic. The test is only positive when the color is a deep cherry or rose-red. The presence of such small quantities of urobilinogen in the urine is for the most part explained by constipation and resulting congestion and escape of some of the blood of the portal system through its collateral circulation. Such physiologic amounts of urobilinogen usually entirely disappear on free purgation. Thus no final diagnosis of impaired liver function is justified except after a free saline purge.

*Urobilinogen in the Diseased.*—In all diseases of the liver and in infections of the bile passages which have reached the liver, or in the presence of obstructions which have backed up the bile the urobilinogen in the urine is increased and constantly present in more than physiologic amounts and gives to the aldehyde reaction, not the physiologic faint rose-red hue, but a deep red coloration.

When the common bile duct is suddenly occluded, the action of the liver cells is rapidly impaired by the back pressure. The bile already in the bowel comes to the liver in part as urobilinogen which is passed by the impaired hepatic cells to the general circulation and appears in the urine for about three days. As the bile in the intestines is exhausted, less urobilinogen comes to the liver and gradually disappears from the urine. The patient may be deeply jaundiced at this time, but with a negative urobilinogen test. The reaction thus may be made to indicate a rapid and complete closure of the common or hepatic ducts. If the obstructing agent after a time allows bile to flow into the intestine, even for a short period, urobilinogen appears in the urine. Intermittent opening and closing of the common duct has in this way been repeatedly demonstrated.

The detection of the presence of bile-pigments in the stools is of little significance. These pigments are nearly always present in the stools of those with the deepest obstructive jaundice; indeed, the intestinal mucosa is often stained deep yellow. Bile is also introduced through the bile-stained pancreatic secretion, about three pints of which are poured into the intestines in twenty-four hours.

Urobilinogen may be absent from the urine in the terminal stages of cirrhosis and syphilis of the liver, when the bile is so altered as to contain almost no biliary-coloring matters. Such a condition has been observed before death in severe phosphorus poisoning accompanied by almost complete fatty degeneration of the liver.

This aldehyde test is one of the greatest aids in the diagnosis of complicated kidney, liver and heart diseases accompanied by ascites. If these three organs are in question, we administer digitalis. If urobilinogen and albumin diminish in the urine, that is, if the liver and kidney conditions improve, the primary trouble is indicated in the heart. If the urobilinogen remains unaltered in quantity and the albumin becomes less, the liver is indicated as the principal causative agent. If the urobilinogen diminishes and the albumin and casts are unaltered, the kidney is probably primarily diseased. This principle, while in practice sometimes obscured, offers in many instances invaluable assistance in diagnosis.

Urobilinogen appears in the urine with the beginning of parenchy-

matous liver degeneration in the advanced stages of all infectious diseases and intoxications. The approach of this point can be noted by testing the urine for urobilinogen in pneumonia, typhoid, pleurisy, myocarditis, pulmonary congestions, etc. The appearance of urobilinogen in pathologic amounts marks the oncoming of greatly increased toxemia and reduced resistance.

*Conclusions.* The urobilinogen test is a very delicate test for impaired liver function. Any localized diseased cells will let pathologic amounts of urobilinogen pass to the urine. The galactose test on the contrary is a general functional test. Galactose is not passed in localized hepatic diseases when the remaining part of the liver has good compensatory function. In the various forms of cirrhosis the galactose test is uniformly positive, strongest in alcoholic cirrhosis. In septic conditions or advanced stages of infectious diseases, a positive galactose test results from liver degeneration. In cases of phosphorus poisoning, chloroform and mineral poisons, liver degeneration is not shown by the galactose test until some days after administration of the poison; in phosphorus poisoning, sometimes not until the second or third week. The great value of these tests for differential diagnosis lies in the conclusions which can be drawn from their combined use, as will be seen from the accompanying table.

The foregoing tests, used regularly by the author are of such value in diagnosis and so easy of application as to commend themselves in the routine examinations of all hospital and private practice. In his opinion, the urobilinogen test will be adopted in insurance examinations.—*Dr. Ira Carleton Chase, (Jour. American Med. Asso., Aug 3, 1912).*

**DELINQUENT YOUTHS.**—This article takes up the very important question of avoiding criminality in the young by means of education and the methods to be adopted for prevention of the development of the criminal instinct. It is pointed out that the courts up to this time have in general failed to reach the root of the matter simply by meting punishment without adequate investigation of the root from which the criminal instinct springs. The interest of psychiatrists in the subject has been of value, particularly with reference to a more painstaking study of weak-mindedness among children. Certain cases are quoted as illustrative of the points made. It is concluded that mental weakness in children often lies at the basis of so-called "crime." Usually this weakness is based on natural or inherited tendencies. Injury to the head may be the cause. Alcoholism in the parents is a particularly deleterious factor. The recognition of mental weakness demands the investigation of psychiatrists together with the observation in the schools.—*Dr. K. Rupprecht, (Post-Graduate, Jan. 1913.)*

**RELIEF OF PAIN IN ADVANCED TUBERCULOSIS OF THE LARYNX.**—Pain is frequently a dominating factor which menthol, cocain, orthoform, anesthesin, etc., do not satisfactorily relieve. Alcohol is injected in trifacial neuralgia, sciatica, etc., with relief in 90 per cent of cases, some recur in 8 months or more and some never. Jelliffe states: "A degenerate process is set up in the nerve trunk, which is recoverable and general sensibility usually returns, but the pain is absent.



The internal laryngeal nerve is injected in tuberculosis of the larynx because it is the sensory nerve to the whole of the larynx except some of the epiglottis which may be cut off. The injection is 75 per cent ethyl alcohol and enough cocain hydrochlorate added to make one per cent. The cocain diminishes the burning.

*Technic.*—Patient in dorsal position, pillow under shoulders, head extended and turned away. Find tender spot (internal laryngeal nerve) in lateral thyrohyoid interval, fix larynx with left hand and introduce needle at right angles to skin. Gradually push deeper and move point around to touch nerve and so get reflex pain in the ear. Do not go deeper than 1 cm. Inject a drop or two. If patient coughs, it is into larynx. If no coughing inject a drop or two more, wait till burning stops (one or two minutes). Then inject a total of 20 minims. Allow at least three days before injecting nerve on the other side.

Out of 25 cases, 2 had no relief, and 8 had partial relief and the others had complete relief. More than one injection may be required.

**AURICULAR FIBRILLATION AND ITS TREATMENT.**—The researches of Mackenzie and others upon the physiology and mechanism of the heart beat has shed a great deal of light upon that common form of cardiac irregularity formerly known as “delirium Cordis” and now termed “Auricular Fibrillation.” In the normal heart, the contraction begins at the junction of the vena cavae with the right auricle, and the stimulus passes downward through the “Bundle of His,” is communicated to the left auricle and to the ventricles. The “Bundle of His,” therefore, serves as an important structure in bringing about co-ordinate action between the auricles and the ventricles.

In auricular fibrillation, the rhythmical contractions of the auricle are grossly disturbed. A condition of fine tremor of the muscle fibres of the auricle develops so that at times, the auricle is in a state of complete paralysis. The muscular walls of the auricle are maintained in a position of diastole thus preventing the complete filling of the ventricle. The many stimuli originating in the irregular twitchings of the auricular muscle fibres are still partly conducted through the “bundle of His,” in turn stimulating the ventricles to rapid, irregular contractions which are readily felt at the radial pulse.

Besides the valvular lesions which frequently occur with auricular fibrillation, enlargement of the whole heart, dilation and hypertrophy of the auricles are common, according to Lewis. A diffuse fibrosis accompanied by a leukocytic infiltration and atrophy of the neighboring muscle fibres are the most frequent pathological changes noted, according to the same author.

Auricular fibrillation occurs at any time between the ages of 13 and 85; very rarely before or after these ages. There are certain clinical phenomena, which, when taken into consideration, give us a fairly positive means of recognizing the condition. These, according to Lewis, are the following:

When the ventricle beats irregularly at a rate surpassing 120 to the minute, auricular fibrillation is almost always present.

When an irregular ventricular action accompanies signs and symptoms of a severe heart failure, it is the result of auricular delirium.

When moderate exercise causes a heart which is slow and irregular, to beat more rapidly and more irregularly, auricular fibrillation should be suspected.

When a patient with a slow and irregular heart beat indulges in moderate exercise and the heart beat becomes slower and more regular, auricular fibrillation is *not present*. The condition is due to some other cause (heart-block, premature beats, etc.).

A persistent irregular pulse is probably always due to auricular fibrillation.

The symptoms of auricular fibrillation differ very little from those of any severe cardiac lesion, excepting that patients suffering from a persistent form of the disorder often complain of fluttering in the chest and neck and are often conscious of the irregular heart-beat. Such patients are also more prone to shortness of breath, exhaustion and other symptoms of over-exertion than are patients with similar valve lesions and a like degree of dilation.

Auricular fibrillation gives an additional significance to every cardiac case with which it is associated; it always denotes serious muscular damage. Few patients survive it more than ten years after its inception. Irregular hearts beating more than 140 a minute, are rarely maintained for more than a few months; rates of 160 or more do not continue for more than a few weeks. Lewis thinks that the rapid reduction of the cardiac rate and its response to suitable treatment, including rest and medication, offers the best guide in determining the prognosis.

The complete physical and mental rest enjoined in all serious cardiac disease should be insisted on in the treatment of auricular fibrillation. Aside from this, the chief measure to be employed in the treatment of the condition, is the proper administration of digitalis and drugs belonging to this group. Lewis states that auricular fibrillation is an absolute indication for the use of digitalis whenever the heart rate exceeds 100 per minute, while the patient is at rest.

Patients suffering from auricular fibrillation, who present themselves with a pulse of 170 to 200, when first seen, are in a precarious condition. Heavy doses of digitalis are needed and not less than 20 to 30 minims of the tincture of digitalis should be given 3 or 4 times a day. Lewis prefers strophanthin given intravenously in doses of 1-250 grain at two-hourly intervals for three or four doses. This often reduces the pulse rate in a remarkably quick time.

Digitalis acts in auricular fibrillation by lessening the conductivity of the "bundle of His," thereby diminishing the number of ventricular beats, by allowing the stimuli of only the strongest auricular beats to be transmitted.—*Med. Rev. of Reviews.*

THE IMMUNITY OF INFANTS TO INFECTIOUS DISEASE.—Although the young infant appears to be particularly susceptible to infection through the digestive tract, causing diarrhoea and enteritis; through the respiratory passages, resulting in broncho-pneumonia; and by way of the skin, causing erysipelas and other cutaneous affections, there is an apparent immunity in the infant to the eruptive feavers, measles, scarlatina, chicken-pox, smallpox, typhoid and diphtheria, and to a certain extent to

tuberculosis also. If young infants were as subject to those infectious conditions as older children, the mortality amongst them would be much greater, as the resisting power of the infant to serious diseases is less the younger he is.

It is impossible to explain this immunity of the infant, though possibly the exceedingly rapid growth and nutritive changes in the young child give the tissues bactericidal properties against certain infectious germs. Whatever the explanation may be, it is important to bear in mind that this immunity to many infectious conditions does really occur, and that epidemics of the eruptive fevers do not occur in assemblages of young children under a year old. When an epidemic of measles occurs in a creche it is rare for it to commence among the little babies. It is almost invariably children between one year and four years who are first attacked.—*La. Clin. Inf.*

MEDICAL TREATMENT OF GASTRIC ULCER.—In the *British Medical Journal* of October 12, 1912, Dawson says that of all drugs he prefers bismuth subnitrate in the treatment of gastric ulcer. In some cases, at the commencement, it has been demonstrated by the x-rays that in the presence of an ulcer some of the bismuth adheres to the raw surface.

The bismuth subnitrate can be taken, as a rule, in powder or cachet form. While the patient is absolutely on milk, 5 grains may be sufficient before each tumbler of milk, and should be continued after all discomfort in the gastric region has disappeared. Later on it may be advisable to give it suspended with a little tragacanth, to which some chloroform water has been added, in the hope that the chloroform will tend still further to diminish any fermentation.

If an alkali is required to diminish the acidity, magnesium oxide is preferable to sodium bicarbonate. Boas has shown what enormous doses of sodium bicarbonate are required. If more than 25 per cent of hydrochloric acid is present, no less than  $2\frac{1}{2}$  drachms of sodium bicarbonate is required to neutralize it. Magnesium oxide will neutralize nearly four times as much hydrochloric acid. As a rule, however, it will be found that the lime-water added to the milk is sufficient in the treatment of gastric ulcer.

Constipation has to be carefully guarded against. Hence the treatment by means of olive oil, as recommended by Karl Walko, may be of service. He gives 100 to 200 grammes of simple olive oil by means of a stomach tube for three to six days. Personally Dawson has had no experience with these large doses, although 20 to 40 grammes of olive oil with sodium bicarbonate, when well tolerated, can often be employed with great advantage. This is best done by means of the stomach tube the first thing in the morning after washing out the stomach. Dr. Faber, of Copenhagen, in a personal conversation, tells Dawson he has obtained excellent results by this method.

The daily use of a small dose of Carlsbad salts is valuable in the latter treatment of gastric ulcer. When the patient has got so well that he can be given ordinary light diet, it is often found that he will improve more rapidly when he takes one teaspoonful of Carlsbad Sprudel salt in half a pint of warm water the first thing in the morning. In



some cases double doses may be required. This second dose should be taken in half a pint of hot water with an interval of at least twenty minutes between the drinking of the two glasses, and there should be at least an hour's interval before breakfast is taken.

In the case of pain, when the hot fomentations and bismuth have not been sufficient to relieve the patient, Dawson prefers to give codeine or morphine.

In the treatment of hematemesis, the complete rest and the ice-bag to the stomach seems to be sufficient, and in order to get the complete rest is may be necessary to give codeine, and for the first two to five days rectal feeding should be avoided. Sterile normal saline solution may be injected directly into a vein in cases of urgent collapse, but good results may often be obtained by simple subcutaneous injection.

In cases of hemorrhage, Dr. Habershon recommends adrenalin chloride (1 to 1000) in one-drachm doses every two or four hours. Dawson himself has used the hypodermic injection of ergot with apparently good results.

RICH MAN'S AND POOR MAN'S GOUT.—F. W. Langridge notes that in talking of cases of arterio sclerosis and cardiac pain associated with the toxic conditions which give rise to heightened arterial tonus, Alexander Morison says: "It calls for treatment by the recognized diet and regimen. The wealthy, over-fed, and idle might do worse than follow Abernethy's advice to such a patient, namely, to live on sixpence a day and earn it, with a little balneological treatment thrown in by way of consolation for their temporary and exemplary self-denial! 'Poor man gout' is usually a consequence of the excessive inhibition of malt and other alcoholic liquors taken to enable him to cope with the excessive labor which is generally his lot, or to procure for him a transient exhilaration and oblivion in his struggle for existence. The treatment of this condition is education and political rather than medicinal, though in statu anginoso the measures which are found to relieve Dives will also be of benefit to Lazarus. A touch of colic makes the whole world kin."—*The Clinical Journal*.

SUPRARENAL GLAND EXTRACT IN CARDIAC DYSPNEA AND CARDIAC DROPSY. Voight in the *Calcutta Medical Journal* for June, 1912, reminds us that digitalis, strophanthus, convallaria, and caffeine are all useful in their turn; but sometimes one and all may fail us.

But there is another remedy which can be relied on in some cases. This is suprarenal gland—the solution of the extract of the gland used hypodermically or by intravenous injection, or the gland substance given by the mouth in tablet form.

Voight has had under his care several cardiac cases in which dyspnea and dropsy were prominent symptoms, and in which suprarenal gland was administered. He gives a report from his notes on two of these cases only. In the others the action of the remedy in combating the symptoms was maintained. In all, more or less severe dyspnea was relieved, sometimes by the hypodermic injection of from 5 or 10 to 15

minims of the 1-to-1000 adrenalin solution (Parke, Davis & Co.), at other times by a 5-grain tablet of the suprarenal gland substance administered by the mouth. When the dyspnea was not very severe, the dose of adrenalin solution injected hypodermically was from 5 to 10 minims (1-in-1000 solution), and the 5-grain tablet of the gland substance was halved for each dose by the mouth. In general practice one cannot always make provision for the amount of urine passed by the patient in twenty-four hours to be accurately measured. But where he succeeded in making such provision while his patients were under treatment by hypodermic injections of adrenalin or by the tablets of suprarenal gland substance administered by the mouth, he almost invariably found the quantity of urine increased and the dropsy at least temporarily diminished by the treatment. Sometimes the apparent effect of the remedy in this respect was marked and striking.

USES OF OLIVE OIL.—The following indications for the use of olive oil are pointed out by the author:

In tuberculosis olive oil is capable of causing a rapid increase in weight. In a young woman suffering from pulmonary tuberculosis he ordered the administration of  $\frac{1}{2}$  ounce two hours after each meal, increasing  $\frac{1}{2}$  ounce per dose every week until 3 ounces *t. i. d.* were taken. The patient, whose weight had been declining, gained twelve pounds in seven weeks and improved in all other respects.

The oil is of great value as a nutrient in wasting diseases. In young children and infants good results may be obtained by its administration by inunction once or twice daily. Babies suffering with malnutrition and stubborn constipation are benefited by the administration of 1 dram of the oil once or twice daily.

The oil is an excellent demulcent laxative in cases of hemorrhoids and fissure of the anus. The author has seen the most stubborn cases of lead colic relieved and the persistent constipation overcome by the administration of a tumblerful of olive oil once daily. On the second or third day there was free catharsis and a subsidence of the nervous manifestations.

Obstinate and painful cases of dry pleurisy may be relieved by the injection of  $\frac{1}{2}$  dram of sterilized olive oil into the pleural sac over the site of the friction sounds.

In progressive anemia, symptomatic or pernicious in type, the administration of equal parts of olive oil and glycerin in gradually increasing doses two hours after each meal is a valuable procedure, oftentimes yielding excellent results.

Rectal enemas of olive oil are highly useful in the treatment of mucomembranous colitis, the constipation of neurasthenia, and in intestinal atony. In typhoid fever the oil, administered as a food in 1- to 3-ounce doses *t. i. d.*, is a valuable adjuvant, assisting to overcome the strong tendency to emaciation. As a laxative it is unequalled in this disease. A high injection of lukewarm olive oil as occasion demands is also very gratifying to these patients.—*Israel Bram, Medical Rev. of Reviews.*

## INFECTIONS OF FINGERS AND HANDS:

1. Never hunt for pus with a probe in this portion of the body, as it may spread infection.
2. An incision should be made through the point of infection, giving free drainage.
3. If pus is secreted about or in the joint of a finger, pressure on the end of the finger will give rise to pain, while if the pus is in the sheath of the tendon, the same pressure will cause little or no pain.
4. The tendon should never be laid open from end to end as this procedure is almost certain to cause sloughing of the tendon.
5. If the tendon sheath is exposed and found distended with purulent or sero-purulent fluid, it should be freely drained.
6. If the whole tendon sheath is distended with pus it will be necessary to drain its upper end. Incisions for this purpose in case of the index, middle or ring fingers should be made in the palm of the hand directly over the tendon involved.—*H. B. Garner in the Detroit Medical Journal.*

THE TREATMENT OF HEMORRHAGIC CONDITIONS WITH NORMAL HUMAN BLOOD SERUM.—Levison summarizes the work that has been done in the treatment of hemorrhagic conditions with human blood. He briefly describes three cases of his own, aged, respectively, nine years, four days, and five weeks, in which very severe bleeding had been successfully controlled by injection of blood serum obtained as a rule from a relative of the patient. Two of the patients recovered; in the third one, aged five weeks, the hemorrhage stopped after a single injection of 20 c.cm., but the child developed hemiplegia several days later and died, probably from a cerebral hemorrhage.

The author states that the term hemorrhagic disease of childhood includes a number of conditions and diseases in which the hemorrhage dominates the clinical picture. These conditions have not been accurately classified because the etiology and pathology are not yet worked out. It is probable that there are a number of bacterial organisms, any of which may produce this hemorrhagic condition in childhood.—*L. A. Levison Toledo, Interstate Medical Journal, November, 1912.*

DIAGNOSIS OF SURGICAL DISEASES OF THE STOMACH.—Vomiting in any of the above lesions is extremely variable, and apart from the presence of blood is of no aid in arriving at a differential diagnosis. In many cases it depends not so much upon the actual disease as upon the consequent mechanical change. Thus, in a large number of cases of chronic gastric ulcer there may be no actual vomiting, although eructation and regurgitation of acid material may be present. In other cases vomiting occurs at the height of pain, which is immediately relieved. If there is any constriction of the stomach, either in the body (hour-glass) or at the pylorus, large quantities of decomposing and fermenting material may be vomited.

In carcinoma, again, the character of the vomiting depends upon the presence or absence of obstruction of the gastric outlet. If there be no



obstruction there is early flatulence and regurgitation of bitter and foul material, while later actual vomiting occurs. In either case it may be associated with slight hematemesis. The amount of vomited material is generally small and, as a rule, it does not give relief, as in chronic gastric ulcer. If there is pyloric obstruction the characteristic type of vomiting found with a dilated stomach occurs early and does not differ from that of obstruction due to gastric ulcer.

In duodenal ulcer vomiting is rare. Moynihan has shown that it is a constant symptom only if stenosis of the duodenum had supervened from constriction of the ulcer. In an otherwise typical case of a duodenal ulcer vomiting points to the coexistence of a gastric ulcer, gall stones, or chronic appendicitis.

When gall-stones are producing severe pain, vomiting is common. It is followed by relief, which, although definite is not generally so marked as in the case of chronic ulcer.

In chronic appendix gastralgia vomiting is frequent, and often is the most marked symptom. It is most evident during the exacerbations of the symptoms, but may even be present between the attacks.

It will be seen that in many cases it is possible to arrive at a diagnosis from a careful consideration of the history, but there are so many exceptions to the common types that it is impossible to diagnose with certainty from this aspect alone. Further evidence can be gained from a careful examination.

In most cases anemia is present. In chronic ulcer this may be due to the loss of blood or to the underlying toxemia, for this is often marked when there has never been any visible loss of blood. Anemia may also be present in chronic duodenal ulcer, gall-stones, appendicitis, or carcinoma of the stomach.

Emaciation and cachexia are likewise useless as a means of diagnosis. In carcinoma they appear late, and they may be present in chronic gastric ulcer.

The ordinary methods of palpation, percussion, and auscultation are of limited value. In gastric and duodenal ulcer there may be an area of deep tenderness of limited extent, and its position may aid in the differential diagnosis between them. Again, in chronic cholecystitis there is generally deep tenderness over the gall bladder, which may be best shown by Murphy's sign. The enlarged gall-bladder, or a tumor of the stomach, may be easily palpable. These last two symptoms are, however, often absent, and a palpable tumor in the stomach points to the disease being far advanced although not necessarily inoperable.

Hertz has shown that percussion and auscultatory percussion are useless to determine either the size or position of the stomach. (*Review*, 1911, p. 295). This is, indeed, what one would expect, for even if distended the stomach may contain solids and no gas. Radiography of the stomach and duodenum after administration of a bismuth meal, may be of considerable value, but there is difficulty in interpreting the results. It has been shown that the stomach is not a simple sac, as was believed, but is divided into a cardiac part, which is more or less saccular, and a tubular pyloric portion separated by the incisura angularis. In an atonic and distended stomach the division may be lost. Care.

therefore, must be taken not to mistake a normal stomach for one with an hour-glass deformity.

In every case of doubt a test meal should be given. Active HCl is nearly always increased in gastric and duodenal ulcer, whilst it is markedly diminished in gastric carcinoma. There are, however, many exceptions, and, as Sherren has shown, too much stress must not be attached to the test meal. He found that, "in those cases in which most help is needed, namely, those with many years' history, which may be chronic ulcer or may have overstepped the line and become malignant, no information is given of any value."

With the gastroscope an admirable view of the gastric mucosa can be obtained, but the two stomach lesions which are most difficult to distinguish are chronic ulcer and gastric carcinoma, and not uncommonly it is impossible to recognize them. Moreover, in most cases the passage of the instrument necessitates general anesthesia and since, in careful hands, the sole danger of an exploratory operation is the small one of the anesthetic, the patient will thereby be exposed to the same risk in return for much less information.

The final and most certain method of diagnosis is exploratory laparotomy. But as in all the above lesions the only satisfactory treatment is an operation, the laparotomy is not performed for the purpose of diagnosis alone. It is the first step in the operative treatment. In the majority of cases a careful investigation will lead to the diagnosis of one of the above lesions. There are a few cases in which one can say with certainty that one of the lesions is present, but it is impossible to say which. Exploratory operation is then desirable, or rather operative treatment is demanded, but the exact nature of the operation can be determined only after the abdomen is opened.

The most important reason for operation is the possibility, even if remote, of carcinoma. This in the early stage is curable, but then the diagnosis is difficult. W. J. Mayo states that "gastric cancer itself does not give rise to diagnostic symptoms during the curable stage." The other lesions are, however, not only so intractable to any other form of treatment and are so readily relieved by surgical measures, but if left are so likely to be associated later with severe or fatal complications that valuable time should not be lost. The indications for operative treatment are as follows:

1. Any case where the symptoms are such that one of the above lesions can be diagnosed with tolerable certainty.
2. Any case commencing after the age of 35, which is not markedly relieved by a few weeks' adequate medical treatment.
3. When symptoms have recurred after previous attacks relieved by medical treatment especially if the symptoms have changed from those typical of a chronic gastric ulcer.
4. Any case in which the stomach shows definite evidence of distension, whether the symptoms are those of ulcer or carcinoma.
5. Any case in which a tumor is present suggesting any of the above conditions.
6. Any case with repeated hemorrhage.

The writer lays special stress upon the fact that if rapid progress

is not made under adequate medical treatment operation should early be resorted to. It affords the only certain method of diagnosis and cure, and if undertaken early many of the more hopeless complications can be prevented. Also in these cases no operation must be considered complete unless the stomach, duodenum, gall-bladder, and appendix have all been examined.—*Dr. A. J. Walton, British Med. Jour.*

VACCINE THERAPY OF TUBERCULOUS ADENITIS.—Gardner reports six cases out of 40 as showing especially well the good results obtained from the treatment of severe cases of tuberculous adenitis by means of bacillary emulsion. He recommends very small doses, 1-15,000 to 1-25,000 mg. as initial dose. The injection is made in the arm, at from four to seven day intervals; the dose being increased very gradually so as not to cause any symptoms. Marked improvement occurred even in cases in which the general hygienic conditions were poor.

The chemistry and mechanism of blood coagulation is not yet settled. The efforts to check hemorrhages by means of calcium, gelatin, adrenalin and styptics have been unsatisfactory. The use of animal serum rather than human serum has not been successful. Human serum never produces toxic results; it should be used in all hemorrhages of childhood. A liberal amount should be used, and it should be continued a short time after the hemorrhages have ceased.—*Will Gardner, Toledo. The Ohio State Medical Journal*, November, 1912.

CERVICAL ADENITIS, WITH SPECIAL REFERENCE TO THE X-RAY METHOD OF TREATMENT.—Dorrance first gives a good review of the subject of cervical adenitis dwelling especially on the channels of infection and emphasizing the etiological importance of carious teeth and diseased tonsils. He comments on the fact that both operative and tuberculin treatment are not productive of especially good results and highly recommends treatment with X-rays. His plan of procedure is as follows: Open air treatment and forced feeding, which all patients of this type should receive; removal of the primary source of infection plus one or more courses of X-ray treatment. The X-ray treatment consists of approximately two exposures a week of about 15 milliamperes-minutes each, with the anode 12 inches from the skin. The rays are filtered through either a sole-leather or an aluminum filter. The patient is protected by sheet-lead except the area which one desires to treat. On the first symptoms of flushing of the skin, treatment should be suspended for at least two weeks. The number of treatments necessary to obtain a cure depends upon the amount of glandular involvement.

By this method the number of recurrences have been surprisingly few and those which have occurred have been cured by a second course of X-ray treatments. All cases of this type should be kept under observation for a period of from four to six months.—*G. M. Dorrance, Philadelphia. The Pennsylvania Medical Journal*, November, 1912.

RESULTS IN THE TREATMENT OF TUMORS OF THE URINARY BLADDER.—The experience at the Mayo clinic with tumors of the urinary bladder is reported by Judd. Up to the present there have been 114 cases, 84 male and 30 female. The average age was 53 years, the youngest 10



and the oldest over 80. The cases are classified as benign and malignant, the former including fibromas and myomas, the latter carcinomas and papillomas. All papillomas are clinically malignant, though some may not show it at first. In 22 of the cases more than half the bladder was involved, and in four the tumor completely filled the bladder. Surgical treatment must be governed by the general condition of the patient and the cystoscopic findings. Arteriosclerosis, renal insufficiency, myocarditis, etc., contraindicate radical measures. Bimanual examination is important to determine the presence and extent of induration. The cystoscopic examination is most important, not only for determining the extent and location of the growths, but also to differentiate a bleeding hypertrophied granulating surface from a true neoplasm. This granulating surface is often seen in prostatic hypertrophy cystitis and particularly in tuberculosis. It is also present in case of tumors, etc., pressing on the bladder from the outside. A stone in the lower part of the ureter may force the mucous membrane down into the bladder and simulate a tumor, but an X-ray picture will usually reveal the condition. When possible it is their custom to excise through the cystoscope a piece for histologic examination. With palpable metastases or much induration at the base of the bladder, the case should be considered inoperable. Without induration, but the bladder apparently filled by the tumor, it may still be operable, as the pedicle may be small and involve but little of the mucosa. Lymphatic involvement and visceral metastases are rare. One of the advantages of the transperitoneal operation is the chance it gives to see the pelvic lymphnodes and the abdominal viscera. The prostate is rarely involved except in the late stages, but, if so, it should be removed with the tumor. The cases are divided into three groups as regards results: The first are those not operated on either for good surgical reasons or because the patient did not remain for treatment. There are 38 of these, and, as far as they have been followed up, the average length from the beginning of the symptoms was 30 months. But not counting three exceptional cases, two very short, one very long, it was 26 months. The second group, 30 cases, includes those where a transperitoneal operation was done. Three of these died in the hospital, 10 are dead and 17 are living, one not heard from. Of the 17, four have been operated on again for recurrences. The average duration of symptoms thus operated on was 18.5 months and the average duration of life since the operation is 24.4 months, and from the first symptoms to death or to the present, 41.5 months. Compared with those unoperated on, these patients have gained an increase of 15.5 months of life. The third group includes cases with pedunculated tumors operated on suprapubically without opening the peritoneum. These numbered 33. One died three weeks after operation. The average duration of life in these cases from the beginning of symptoms to the time of death or to the present is 46 months. Allowing 26 months in cases without operation, they have gained 20 months each. The better results in these than in the second group is probably due to the fact that in the latter the growths were more infiltrating and malignant. The importance of cauterizing the edges of the wound or of operating entirely with the cautery is especially emphasized. The high-frequency current is a very

useful adjunct in the treatment and has been employed in 17 cases, including 11 of recurrence. The villous growths on small pedicles are most favorable for this treatment. On account of the great tendency to recurrence it is the custom at Rochester to use the cystoscope with these cases every three to six months for two years after operation; in this way the appearance of recurrence is discovered and treated early with the high-frequency current. They believe that the general results would be much better if diagnosis and treatment could be earlier obtained than is usually the case.—*E. S. Judd, Rochester. Journal American Medical Association, November 16, 1912.*

THE FRIEDMANN TREATMENT OF TUBERCULOSIS.—This matter was discussed at a meeting of the Berlin Medical Society. Hr. Friedmann on the occasion added somewhat to his previous pronouncement. He repeated that he had not said what his curative material consisted in. Whether he will act up to the traditions of the noblest of professions, or as a quack—keep his secret and *sell* it to the highest bidder, and so make a fortune for himself out of it still remains to be seen. "I have thoroughly tested many and many a kind of avirulent cultures, also such as were obtained from the human subject, that had been rendered avirulent by various methods, but I have quite given them up."

In fact, he had made use of the most varied non-virulent kinds—those from warm-blooded animals that had been made avirulent, others from the most diverse cold-blooded ones. In 1903 he had published results of investigations into tortoise tubercle. In 1904 he made a further communication on a second tortoise strain. If the first strain was only slightly virulent, it set up nodules in the guinea-pig that never led to tuberculosis; still the nodules could be felt year after year. A third strain was discovered, a natural one that showed avirulence in a high degree, and concerning this he had never published anything. Even in its natural state it was perfectly harmless for guinea-pigs it caused scarcely any nodules, and in a short time it lost the last trace of virulence. He then used the preparation more extensively, and on the human subject. His preparation was, therefore, perfectly harmless for guinea-pigs. Animals that had been injected two and three years were perfectly sound and free from nodules. He might also state that he had experimented with other cold-blooded animals, fish, salamanders, blind worms, snakes, also with other tortoises, but, without exception, with results that were not good.

Hr. Erich Müller said they had just heard from Hr. Friedmann that his form of bacillus was not from the human subject or from cattle, but from some cold-blooded animal, the bacilli from which were quite avirulent for man. The recoveries he had seen were such as were not possible by any other known means. He believed also that children injected would be safe from infection. A child shown by Friedmann was very remarkable. Like many similar cases, it showed the harmlessness of the injection, and spoke strongly in favor of the protecting power of the preparation in that in the midst of a tuberculous milieu it had remained free from the infection. The protective inoculation had been then made about a year. For the future—the immediate future, at any rate—they would limit their injections to children that were ill.

Hr. Kausch would ask them to restrain their enthusiasm for the present, and bear in mind Koch's first pronouncement and salvarsan in syphilis.

Hr. Piorskowski related some details of the work he had done for and with Friedmann, and concluded that the culture, some of which he had brought with him to show, looked exactly like human tubercle, and behaved exactly like it in the incubation oven. For that reason he believed that the tubercle from the great tortoise of the Berlin aquarium was of human origin, and was to be reckoned as of the *typus humanus*.

Hr. Aronsohn would like to know the dose given by Friedmann—i.e., the number of bacilli he injected. He could only understand by the simultaneous method that a smaller dose than usual was given in each, and that the absence of abscess formation was due to the smaller quantity injected.

Hr. Wolff-Eisner said that no proof had been brought forward that the injections were harmless. In that short time it was impossible to say that they were harmless. It was also possible that some of the cases recorded as cured were not really cases of active tuberculosis.

Hr. F. Meyer would like to know whether Friedmann had submitted his cases of cure to the tuberculin test. The cases that had been shown would have got better by tuberculin treatment. He could not take it that Friedmann had said that they were cured. He would raise an energetic protest against protective injections, both on ethical and scientific grounds.

Hr. Bier had seen a number of Friedmann's cases. He must confess that he had received the impression that there was a decided curative action, but he had not so far seen any decisive proof.

Hr. Schwenk said that he could not altogether agree with what Friedmann had said. There was one case which his colleague (Hr. Friedmann) had described as cured. He (Hr. Schwenk) had seen the case the day before. There was no question whatever of a cure, nor even of improvement. The patient was sent to Friedmann in 1911. She had about six injections. In August of last year, she was again under treatment, and had two injections. She reacted with a universal urticaria, which lasted for several days. She was no better.

Hr. Katzenstein said that in surgical cases of moderate degree we had in tuberculin such an excellent remedy that we had no occasion to have recourse to an unknown remedy.—*American Medicine*.

MEDICAL EXPERIENCES IN THE BALKAN WAR.—While to the great majority of those who live in America, the war in the Balkans is quite unreal, we occasionally get word from correspondents or returning travelers which leaves no doubt that to a great many the existing conditions have all the reality of warfare in its most fearful and terrifying phases. As in every war of modern time the medical service has undoubtedly been put to a severe test, and according to the *London Lancet* (Nov. 23, 1912) interesting information is forthcoming as to the work which is being accomplished by the surgeons attached to the contingents of the Red Cross Society and the Knights of Malta in the Balkan war. From this country there have gone to Bulgaria, to Montenegro, and to Servia 50 surgeons, who are in charge of about 2,000 beds. One of them, Dr. Fedlicka, states that he has had an opportunity of observing



670 cases of severe wounds in Servian soldiers, and expresses his surprise at the rapidity of healing and the aseptic condition of even the most dangerous injuries. Men shot through the body by bullets which penetrated the liver, the lung, the spleen, and the intestines recovered after a fortnight or so without much evidence of ultimate harm. The modern bullet is rendered aseptic by the enormous heat of the burning powder, and it hardly ever shatters long bones, so that there were very few amputations—only two in 670 cases—and only 20 instances in which plaster of Paris bandages were necessary. A large number of fractures of the bones at the base of the nose were seen in Turkish soldiers who were not accustomed to use rifles, and in consequence of the recoil received blows in the face from the stock when the weapons were fired. Dr. von Oettingen says that he has found that the use of mastical, a resinous, very sticky substance, for the first treatment of wounds gave him excellent results as it hindered the entrance of micro-organisms and prevented their multiplication. The forces of the Slavonic nations carry in their outfit a first-aid package arranged after the Norwegian or Russian pattern, and about 95 per cent of the wounded were found to have made use of this package. The severest wounds were those inflicted by the bayonet, and they also healed with more difficulty than bullet wounds. Shrapnel and other projectiles fired from heavy guns did great damage, mostly killing the victims. The sanitary precautions in the allied armies seem to be excellent, but not so on the Turkish side. But in Montenegro, where there is a sad lack of all medical requisites for the war, the Austrian Red Cross Society has undertaken an immense amount of work. As a rule the wounded recover sufficiently to be able to return to the front after a fortnight, but those with wounds of the abdomen or skull are not in this category. Up to now it has been possible to prevent any serious outbreak of cholera, plague, or smallpox amongst the prisoners, captured by the Balkan armies.

*Tuberculin.*—The return of tuberculin to favor is one of the amazing changes caused by the recent studies of tuberculosis. We are informed that more than half the sanatoriums of continental Europe are now using it in minute doses measured by the millionth of a milligram as a unit. They claim the cure is quicker, more lasting and with fewer relapses. The original mistake was in giving it in such large doses that it merely added to the toxemia of the patient and hastened his death. It is now claimed that the minute dose stimulates the production of anti-bodies. This seems to confirm the new theory that we all acquire immunity by minute and repeated infections in childhood. It may explain the remarkable results of carefully regulated exercises which release autogenous toxin, and it fully explains the cures following a change from a sedentary to an active occupation. Of course outdoor life must be given the main credit, but the cures seem quicker and more permanent than in the cases of men who give up all occupation. At least these are the claims made in England a few years ago. It does seem that we have made another step forward in the prevention and cure of tuberculosis, and a big step too. The lesson to be drawn, is that we must avoid doing anything to a man, sick or well, which will break down the defences he has been laboriously erecting all during his life against his own tuberculosis.—*Editorial—Amer. Medicine.*

## Monthly Retrospect

### OF HOMOEOPATHIC MATERIA MEDICA AND THERAPEUTICS

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CONDUCTED BY A. LEIGHT MONROE,

Miami, Florida.

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THE STORY OF ACONITE.—The Aconite person is plethoric, of lively disposition, bilious and nervous constitution, brown or black eyes and hair, deep color in the face. Subject to active congestions.

Aconite affects that part of the sympathetic nervous system controlling the heart and arteries. Hughes calls it "our great febrifuge." It increases the heart action and is the great remedy for congestion of the capillaries. It affects the heart, arteries, the sensational nerves, the serous membranes, muscles, joints and digestive organs.

Fever resulting from exposure to dry cold air, congestion of the capillaries, in a word; even if after some length of time an ailment can be traced to exposure to cold air, Aconite will cure it.

Fear is a great key-note. Anxiety, does not know why he is afraid, but the anxiety is insupportable. This leads one to look to the condition of the heart. Children are afraid to go alone into the street, even to leave the doorstep of their own house; the patient is sure even when he has but a trifling ailment that he will die. Fear is as much a guide to the use of Aconite as tears are to the Pulsatilla patient. Fears he will go crazy.

Whatever the complaint when there is this intense fear it is well to think of Aconite.

Blood spitting when the blood comes up easily after mental excitement, coughing, exposure to dry air; this condition comes from congestion of the lungs with blood, due to irregular heart action—hence we trace the key for the use of Aconite—congestion. Nose bleed of plethoric persons.

Croup where the child goes to bed well and wakes up in the night with a cough like a dog bark and greatly frightens the mother. Aconite will relieve at once.

When the baby cries and will not be comforted and we can not see why it should cry, Aconite will often relieve it.

Ophthalmia, particularly from cold winds. It is often the only remedy needed. Inflammation of the eye from foreign bodies, when even after the substance is removed the patient is sure it is still in the eye. Great sensitiveness to the light.

Neuralgia of the face, congestive toothache, toothache from cold. Great sensitiveness of the scalp. Whole body sensitive; can not bear to be touched.

Numbness. Tingling of various parts of the body; numbness especially of the left arm.

Dentition difficult. Baby bites its fingers, is restless, cries, gums greatly congested.

Patient rises up in bed, the red face becomes pale.

Amenorrhoea of young girls, of sedentary life, tendency of blood to head, or chest. Haemoptysis instead of menstrual flow. Menses suppressed from fright. Amenorrhoea in plethoric women.

Fainting. Young girls, especially at the time of first menstruation.

Dyspnoea. When the new born baby fails to urinate Aconite will often remedy the trouble.

Sleeplessness. Patient cannot sleep, restless, worse after midnight. Lies thinking of dreadful things that will happen, that he will die.

The mental symptoms are most important. In a word, Aconite is indicated where there is fear, anxiety, primary fever, ophthalmia, neuralgia, spasmodic croup, haemoptysis, numbness of various parts of body. Ailments from cold, dry air.

It has been said that the medicinal plant is useful for complaints common to its natural habitat. Thus the Aconite grows on mountainous regions and is particularly useful in ailments arising in cold and dry regions. Pulsatilla is of value in complaints common to low damp districts. Complaints from wet feet. The Pulsatilla patient is a moist person and the anemone grows in wet low grounds.

If we, as a school, would depend more on Aconite in initial fevers instead of many of us employing the depressants donated to our notice by the pharmaceutical chemists, our patients would get well quicker and more pleasantly, and we should feel more confidence in homoeopathic medicine.—*The Homoeopathic Recorder*.

T. L. BRADFORD, M.D.

THE VALUE OF HOMOEOPATHIC REMEDIES IN POSTOPERATIVE CASES.—I may here give the standing orders that, as a rule, govern my hospital practice, in serious post-operative cases:

*Camphor*.—When the patient comes down from the operating room she (or he) receives three doses of Camphor ix, three drops, at intervals of fifteen minutes, provided there is sub-temperature and the blood pressure is low.

*Veratrum Album*.—If reaction is not prompt the Camphor is followed by Veratrum Album 3x, three drops every hour or half hour until the temperature reaches normal. This is particularly called for by the usual symptoms of cold sweat, etc., etc.

*Cuprum Arsenicosum*.—When the temperature reaches normal and nausea and vomiting develop with thirst and pain Cuprum Ars. 6x is given three drops hourly until relieved.

*Nux Vomica*.—If there is simply nausea and disgust for or as a result of the anæsthetic, Nux V. 3x is given hourly until relief.

If nausea continues unduly, choice is made from the following—Apomorphia 3 tr., Ipec. 3x or Tart. Emet. 6x.

*Arnica*.—For trauma. If there has been undue handling of tissues, as in abdominal cases at times, great relief from the ensuing soreness



is obtained from the exhibition of Arnica 3 or 6, two or three drops hourly, and I have been led to believe we may thus avoid further trouble.

*Belladonna*.—After operations there is at times a re-actionary temperature, with great tenderness in and about the part, with flushed face, headache, etc., then Belladonna brings great relief.

*Bryonia*.—If the tenderness is not quite so acute, but there is much soreness locally and all over, with coated tongue and thirst, Bryonia is very effective.

Peritonitis or pleuritic invasion is often cleared up by the use of Bryonia.

Not infrequently dysuria follows an operation, especially an abdominal one, and is often relieved by Hyoscyamus; or if there is anuria, Canth. or Terebinth., according to their well known indications.

A most troublesome complication after abdominal operations is flatulence or meteorism. Raphanus is an excellent remedy, but there are many others. Nux V.  $\text{rx}$  will sometimes cause expulsion of the gas, but we have Magnes. Phos., Colo., Asaf. and many others.

For a general febrile condition we have the old tried remedies, such as Acon., Ferrum Phos., etc., etc.

For septic absorption with "churchspire" temperature chart, much can be gained by the use of Chin. Ars. 3 tr., three grains every two hours.

For phlebitis, the sheet anchor, I believe, is Hamamelis internally and externally. A case may require Bell., Puls., Rhus., or Lachesis according to indications.—*Jour. Amer. Institute of Hom.*

J. H. McCLELLAND, M.D., PITTSBURGH.

**KALI CARBONICUM.**—A woman of seventy years, alcoholic, with a bad heart, had been previously dosed with Digitalis under allopathic treatment. She complained of cough, which was "racking her to pieces," but gave nothing of generals upon which to prescribe and particulars were not of much value.

I gave her some medicine which had little, if any effect, and it was not until the third visit that I obtained the information that "it is always worse at 3 A. M. and continues until 5 A. M."

Kali-carb. 30, a few doses, cured the cough.

This was a year ago and at the present time the patient is very much improved; the cough, which she said she had had for years, has not returned, and her heart is stronger.

2. I was called to see a man of forty years, suffering intense pain. A very short examination sufficed to afford a diagnosis of "malignant disease of the liver." This organ occupied the larger part of the abdomen, reaching down to the right iliac fossa and extending across in an oblique direction to the left. It was tender, and nodulated masses could easily be felt by palpation.

There was a case in which morphine sulph. should be given. It is easy to inject morphine; that should not satisfy a homœopath. I did not give morphine. I sought for something on which to base a prescription and found it in a *nightly aggravation at 3 A. M.*

I gave him Kali-carb. 30, a few drops in a glass of water, to be given

half-hourly until relief was obtained. The man died five days afterward, but those five days were days of peace. Kali-carb. eased his sufferings, and his relatives said that the medicine had given him more relief than any he had taken previously.

When we know our materia medica we do not have to resort to narcotics, etc.—*F. J. Whaler, M.D., The Homoeopathician.*

**FERRUM.**—The Ferrum patient is typically a tubercular one. They always have been since birth. They begin to show the ferrum expression of the tubercular taint more prominently about puberty and on up to the 25th year. Their circulation is so easily disturbed that they flush up and become red in the face on the least emotion. They are as children, bashful, timid and changeable in their dispositions. They are always blushing when meeting strangers or when embarrassed. They often speak of their face being hot while their extremities are cold.

**FERRUM PHOS.**—Ferrum Phos. is prepared by mixing sodium phosphate with sulphate of iron. It is found in the coloring matter of the blood and hair. It is practically a new remedy, although we have had some provings of it as far back as 1875, yet the finer and more useful phases of the drug were not brought out until the latter part or beginning of the nineteenth century.

Schussler brought out many symptoms that gave us a better knowledge of its action. It is sometimes called the new *aconite* of the materia medica, as it relieves so many acute congestions similar to those of *aconite*. The guiding symptoms speak prominently of its acute congestions, especially to the head; of its nose bleed, its red face, its hammering pains etc.

Dr. Hemple, speaking of iron as a remedy, says, "Those living in the vicinity of iron springs are prone to pneumonia, haemoptysis, pulmonary phthisis, nose bleed and vomiting of blood."

**Mental Symptoms.**—Feels as if he needed a stimulant; a feeling as of letting down, inertia, loss of courage and hope.

Iron we know possesses the power of attracting oxygen, and through this power the *ferrums* are useful remedies in certain changes in the red blood corpuscles, such as anaemia, chlorosis, leucaemia, even of their basis are of a tubercular character.

There is congestion to the brain, lungs or any part of the body, accompanied with pain, heat, redness, swelling and rapid pulse. In eruptive fevers or inflammatory conditions, especially in young people or children, it vies with *aconite*, *bell.* and *gels.* It seems to come in midway between *aconite* and *belladonna*. It has not the intense restlessness and anxiousness of *aconite*, nor the drowsiness of *belladonna*. Its delirium and mania are more modified. In fever the face is flushed like *belladonna*, the pulse quick like *aconite*, yet we do not have the intense heat or the photophobia of *bell.* The pulse is softer, not so tense and hard.

In pneumonia the face is flushed and the patient sleepy and drowsy, with a tendency to hemorrhages from the nose in young people. It has sharp pains in the lungs, and stiches in the sides like *bryonia*. It is fre-

quently indicated in bronchitis, laryngitis, pleurisy and pneumonia. The chest in pneumonia has a sore, bruised feeling. The expectoration is scanty and often blood-streaked. There are sharp stitches in the sides which are worse on taking a long breath. The cough is hard, dry, short, tickling and often spasmodic with a huskiness, and more or less loss of voice. *Ferrum phos.* has a tickling cough beginning in the larynx like *rhys.* Pulse full, round but soft.

I have cured many severe cases of articular rheumatism with this remedy in brunettes, where the pain frequently shifted from one joint to another. The symptoms are painful swelling with heat, soreness and tenderness lasting three or four days, which suddenly ceases, beginning just as suddenly and as severely in the opposite joint. The fever is high, face flushed, and there is much suffering and restlessness; the patient is aggravated by motion, and relieved by wrapping up warm. Nose bleed of bright red blood. Compare with *malilotus alb.* Frequent bleeding of the nose in children at puberty (*cal. phos.*). These children all have a tubercular diathesis. Nose bleed in adults relieves headache. The toothache is relieved by cold drinks and is aggravated by warmth. Toothache with fever and red flushed cheeks. Fever with flushed face and cheeks red, eyes glistening.

*Stomach.*—Acute gastritis; pain worse after eating; nausea, and vomiting of a sour matter which sets the teeth on edge. Stomach worse from eating sour things, meat, fish and coffee. Aversion to milk.

*Diarrhoea.*—Stools green and watery, mixed with mucus. Dysentery begins with high fever. Child sleeps with eyes half open, moans and complains all the time (*arsenicum*). Straining at stool often accompanied with retching and vomiting. Stools almost pure blood or green watery mucus mixed with blood. Aggravation from midnight until morning and from retention of urine in fevers of children.

*Skin Symptoms.*—Skin dry, hot in fevers. Much heat in the face. Capillary congestion with burning in the skin. Indicated in the beginning of scarlet fever, smallpox with violent fever, and cerebral congestion, also in erysipelas with intense fever and congestion, especially in tubercular children.—*J. Henry Allen, M.D., The Critique.*

*Ferrum.*—Pallor is one of the key-notes of ferrum. Pallor of the skin, of the mucus membrane, of the face, alternating with flushes. Farrington says: "They have irregular distributions of the blood. Pale when quiet, flushed when excited." They have orgasms of blood to the face, chest, head, lungs, heart, and especially to the cheeks. The face is pale with a red spot on the cheek. They are peevish, tearful, fretful, disputive and contradictive. The lips, tongue, gums, and palatal arch look pale and anaemic.

In young girls we often see that waxy death-like face, with bright eyes and long silken lashes, who are willful, fretful and contradictive. Later on as they develop into riper womanhood, they are apt to look chlorotic, cachectic and bloodless. The face is often the dial to these patients. motion flushes the face on meeting strangers, drinking wine or the slightest stimulant. The nose, ears, lips, fingers look waxy, and are cold to touch. The muscles are flabby and relaxed, with no strength or tone in them. Still later on we see them losing strength daily. They



faint easily and tire soon. They are made better by moving gently about, in cool fresh air like *pulsatilla*. They often look well, but have no strength. They love to rest, to lie down and keep quiet.

H. C. Allen describes a ferrum patient as "pettish, disputive, easily excited and angered, contradictory and of a sanguine temperament." They have vertigo which is greatly aggravated by seeing flowing water, crossing a bridge, or walking over a river or stream from and descending (*borax*).

In their headaches they have sensations of hammering, pulsating or beating, coming on two or three times a week. These headaches are often due to the anaemic condition usually present in ferrum patients. They are often accompanied with congestion in the head, flushes of heat to the face or redness of the cheeks. They have a severe, dull, heavy feeling in the head in the morning, alternating with cold feet. The feet and hands are as cold as marble (*cal c.*). Pain in the parietal region often calls for *ferrum*.

The taste is sweetish or of blood; of blood usually during the menses (*phos., tub.*). Chilly all over with hands and feet cold and face glowing hot. Sensation of heat over the body which is cold to touch.

*Menses*.—Flow bright red accompanied with much flushing of the face (*ipéc.*). Face usually pale or sallow. In hemorrhages this remedy comes in between *china off.* and *ipécac.* The hemorrhages come in gushes, bright red, with or without clots. Occasionally we have a throbbing or beating headache accompanying the menses, with dyspnoea, rapid breathing and palpitation of the heart. In incipient tuberculosis the sputa is copious, putrid, purulent, greenish or frothy and scant. Early attacks of hemorrhage of bright red blood are followed by fainting spells (*incipient tuberculosis*).

*Skin*. Great paleness of the skin, face flushes easily or is pale and ashy, jaundical complexion, dark blue rings about the eyes and circumscribed dark blue or violet-colored spots on the skin (*purpura*), and varicose veins during pregnancy. Skin dry, pale, waxy, or dirty looking, withered and flabby. Yellow brown spots on the skin which are sore to touch. Ulcers pale, oedematous in chlorotic individuals.

*Aggravations*.—12 a. m., from asthena. Worse while at rest, sitting still. Better walking slowly about and also better in summer. Worse fall and spring.—J. Henry Allen, M.D., *The Critique*.

CHROMIUM SULPHATE.—Dr. G. T. Fuller read before the Kentucky Eclectic Medical Association an interesting article on this drug based on his experience of eight years' use. He concludes that the drug spends its force entirely on the nervous tissues, "and is not only a tonic to them but a food as well. If not a food in fact, it so stimulates the nerve tissues that they appropriate to themselves nourishment from the blood plasma, in the way of phosphorus, magnesia and potassium cell salts and other material necessary to their normal health and functional activity. The drug is indicated in the functional wrong of any organ where that wrong is due to lack of nervous tone or impoverishment of the nerves supplying same. It is indicated in a few structural wrongs in addition, in organs or tissues extra to the nerves themselves, as, for

instance, in goitre and exophthalmic goitre. I have yet to see a thyroiditis that did not gradually respond to its influence, not excepting the exophthalmic variety, with its accompanying symptoms of bulging eyes and tachycardia or rapid heart-beat. It surely and steadily inhibits the vagus, and by that means slows the heart and relieves the tachycardia, and I believe that it is the inhibitory effect of the drug through the vasomotor system, controlling the blood supply of the glands, that cuts off its nourishment and, as it were, starves the disease out. Not only do I think that it inhibits through the ganglionic system, but also through the pneumogastric, or, more correctly, through one of its branches, the recurrent laryngeal.—*Pacific Coast Jour. of Homoeopathy.*

**IPECAC.**—Quite recently I had a patient with hemorrhage following a miscarriage. The sensitive, brown-eyed, auburn-haired woman of sallow complexion was losing a considerable amount of dark, clotted blood. Belladonna had been given with no effect. In addition to the clots there were intervals of "gushes of bright red blood."

At the second visit she was not improved, losing considerably, and I was seriously considering the question of retained products of conception. (What came away at the miscarriage had not been saved for my inspection.)

The patient suddenly volunteered the assertion: "Doctor, I know when the gush of blood is coming, as I feel very sick, and there is an opening and shutting sensation inside" (uterus). The nausea was very definite before each gush of blood.

I left a few pellets of IPECAC 200 in some water, with instructions to take one dose and wait two hours. Two doses cleared the case.

Such cases as this are often needlessly curetted because the prescriber is out of touch with his materia medica, and fails to recognize the indicated remedy.—*F. J. Wheeler, M.D., The Homoeopathician.*

**ANGINA PECTORIS.**—Of the modern remedies for this condition Clifford Allbutt recommends as most efficacious the high-frequency current and Metchnikoff's lactic acid bacillus. Baths and massage should not be prescribed in any urgent stage of the disease. Patients should be warned not to swallow quickly, or to bolt large morsels.—(*Med. Standard.*)

**THE LUTIN REACTION.**—Kammerer (*Munch. Med. Woch.* 1912, S. 1534) tried injections into the skin of 65 specifics and 43 non-syphilitics, using the Lutin prepared by Noguchi. Of the syphilitics, 21 reacted positively, of the non-syphilitics only one. The changes of the first two days were not looked upon as diagnostic, but the reaction was read after the second day and the patients were observed for at least two weeks. In order to react the syphilitic must be in a state of allergy. Kammerer believes that the extract may become weaker after a certain time and fail to give reactions. In some cases the control site reacted as violently as the luetin site in specifics. This Noguchi calls Umstimmung. The author concludes that the test of Noguchi is harmless, specific, and useful for the practising physician.—*Med. Rev. of Reviews.*

# THE HAHNEMANNIAN MONTHLY.

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MARCH, 1913

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## RHUS POISONING.

BY

JOSEPH C. GUERNSEY, A. M., M. D., PHILADELPHIA.

*The United States Pharmacopœia*, 1907, says the genus RHUS contains various species which have the property—probably even without direct contact—of so violently irritating susceptible skins as to produce severe poisoning. Of these poisonous species there are six recognized in the United States by most modern botanists:

*Rhus Vernix* (*R. venenata*) swamp sumach, poison sumach, poison elder.

*Rhus Michauxii* (*R. pumilla*) a rare Southern species, growing in upper Carolina and Georgia, not more than a foot in height. According to Pursh, it is the most poisonous of the genus.

*Rhus Diversiloba* (*R. lobata*), yeara, is found on our Pacific border.

*Rhus Metopium*, mountain manchineel, coral sumac, a West Indian species growing also in the "hummock" lands of Southern Florida. It is exceedingly poisonous.

*Rhus Toxicodendron*, poison oak, of the Southern States.

*Rhus Radicans*, poison oak, poison ivy, whose fresh leaves were formerly official in the U. S. Pharmacopœia under the name of *Rhus Toxicodendron*.

It is well to remember that *not all Rhus plants are poisonous*, there being at least two exceptions—*Rhus aromatica* and *Rhus glabra*; both of these are harmless. *Rhus aromatica*,



commonly known as fragrant sumach, sweet sumach, has three leaflets (like *Rhus tox.*); the crushed leaves are sweet-scented. (*Rhus tox.* when wounded emits a milky juice which becomes black on exposure to the air.)

*Rhus glabra*, commonly called smooth sumach, upland sumach, has leaves upon smooth petioles which consist of many pairs of opposite leaflets, with an odd one at the extremity (like *Rhus ven.*); in the autumn their color changes to a beautiful red.

*Country Life in America*, June, 1912, contains a practical and interesting description of

"Three poisonous plants which it is well for all mankind to avoid—*Rhus toxicodendron*, *Rhus diversiloba*, *Rhus venenata*, commonly called poison ivy, poison oak, poison sumach."

The essay, by Charles Monroe Mansfield, M. D., is instructively illustrated by photographs which, with his permission, are here reproduced.

*Rhus toxicodendron* (*radicans*) (τοξικον poison, δένδρον a tree) grows abundantly throughout the United States with the exception of California and western parts of Oregon and Washington, where it is replaced by the equally poisonous *Rhus diversiloba* also called "poison oak." (Fig. 1, notice the close resemblance of its leaves to those of the common oak tree.) *The Homœopathic Pharmacopœia of the United States* makes no mention of *Rhus diversiloba*, but in that excellent little work, *Index of Provings*, by T. L. Bradford, M. D., there are two references: (Moore: Amer. Hom. Obs. V. 15, p. 648; Annals Brit. Hom. Soc. V. 8, p. 466). Mention is also made of *R. diversiloba* in the *Homœopathic Physician*, Vol. 8, p. 503.)

This paper is confined to poisoning caused by *Rhus toxicodendron* (*radicans*) found as an ivy creeping along fences, climbing high up the trunks of trees, clinging to rocks and piles of stones; it also appears as an erect shrub, one to three feet high; and to poisoning caused by

*Rhus venenata* (*vernix*) a handsome shrub or small tree usually ten to fifteen feet high, but sometimes thirty feet, found in swamps and swampy localities.

As it is generally considered that *Rhus radicans* and *Rhus toxicodendron* are mere varieties of the same plant, and as the dermatitis produced by each is identical and requires the same



FIG. 2.—*Rhus toxicodendron*, showing its distinctive three leaflets and fruit.



FIG. 1.—*Rhus Diversiloba*.

medical treatment, the term *Rhus toxicodendron* is here used to cover both.

Common names of *Rhus radicans* and \* *Rhus toxicodendron*: Poison ivy; poison vine; poison ash; poison oak; poison creeper; mercury; markry; markweed; pickry; trailing sumach.

Common names of *Rhus venenata* (*vernix*): Swamp sumach; poison sumach; poison elder; poison dogwood; poison wood; varnish tree; poison ash; quick-will; thunderwood; sulphur wood; poison tree.

These plants are here presented in a manner that, it is hoped, will aid in their quick and correct recognition.

*Rhus toxicodendron* is a deciduous, trailing or climbing vine, stem five to forty feet long with numerous radicles by which it adheres to tree trunks (Fig. 4) and fences and rocks, which it ascends like ivy—hence the name “poison ivy.” *When it cannot attach itself to a tree or fence or when it is cut back by the farmer’s scythe or the browsing of animals, it will grow erect like a shrub.* It is absent on high mountains but it grows abundantly through the country, low-lying meadows and river bottoms being its favorite localities; also it appears everywhere in ravines, in the open woods and on the borders of woods and along river banks; it is spread largely along highways and cultivated fields. It is an unusually beautiful plant with THREE, angularly indented (Fig. 2) glistening leaflets which are pubescent beneath. (The Virginia creeper, (Fig 3) often mistaken for poison ivy, has five leaflets.) The yellowish-green flowers of the ivy appear in May and June; the smooth, waxy, whitish-gray, oval fruit remains on the plant until late in the winter (Figs. 6 and 7).

*Rhus venenata* (*vernix*) (Fig. 5), less common and less known but more poisonous than *Rhus tox.*, grows in swamps or swampy ground.

This plant, tree-like in form, with dark gray bark, reaches the height of twelve, eighteen and even thirty feet with a trunk six inches in diameter; its wood is filled with a yellow pith which is very poisonous and has a strong sulphurous odor. The leaves are † pinnate with four or five pairs of opposite

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\*In medical literature *Rhus tox* is sometimes confounded with *Rhus ven.*—swamp sumach—which is a totally different plant.

†A leaf consisting of several leaflets arranged on each side of a common petiole





FIG. 4.—Contrast this poison ivy with the Virginia Creeper in the left-hand illustration. Both vines are beautiful.



FIG. 3.—Virginia Creeper, often mistaken for Poison Ivy.

leaflets and an odd terminal one; the individual leaflets are thin, dark green, rather shiny on the upper side and light green underneath. Flowers are yellowish green, inconspicuous, appear in May and June. Fruit is a greenish white or yellowish berry, grape-like in form, hanging in loose clusters. The very prominent leaf scars and sharp pointed buds covered with a slight purple scale appearing in cold weather make it possible to recognize poison sumac in winter. The tree is poisonous in winter as well as in summer—as are other *Rhus* plants. Sumach poisoning (*Rhus venenata*) is often contracted on fishing trips, when walking through a marsh.

Some people are immune to the toxic effect of *Rhus* poison all their lives; others enjoy immunity for a shorter or longer period which may come early in life or late in life.

Animals seem immune to *Rhus*; horses, pigs, sheep and goats eat it without ill effects and birds feed upon the fruit. With human beings it is sadly different as the plant poisons, with varying intensity, the skins of most people; some are so susceptible that they cannot bathe in a stream which is in contact with its leaves or roots—cannot even walk in the fields or woods during the flowering season because the pollen from the flowers, carried by the wind, comes in contact with and affects their skin.

Probably no acute disease causes more suffering than *Rhus* poisoning and it is always the result of personal contact, in some manner, with one of the *poisonous* *Rhus* plants.

The real active principle, which does the damage, is a fixed oil found in the leaves, stems and in all other parts of the plant whether fresh and green or old and long since dried out. Dr. Mansfield says: "Extreme cases of poisoning have resulted from persons coming in contact with smoke from a fire in which the wood of these plants is burning, showing that even the small particles of the oil released by the heat and carried up by the smoke, are as injurious as direct contact with the plants themselves." *Rhus venenata* yields a larger percentage of the oil than *Rhus tox.*, but there is no difference between the two oils. When either is applied to the skin it causes the well known eruption.

It appears to be proven, from experiment and observation, that the poison of the *Rhus* plants does not enter the circulation but remains as a local affection.

The most likely and most dangerous time of infection is in



hot weather with the sun shining brightly, when the plant is most active and when the skin is most receptive in addition to being less protected by clothing, etc.

Rhus plants are gathered for medicinal use after sunset, on cloudy days, from shady places.

*Prevention.*—There is no prophylaxis beyond prompt and vigorous measures to neutralize the poison and thus prevent its development. When called to a case of Rhus poisoning, *immediately cleanse and neutralize the places not yet affected.* This is truly “First aid to the injured”! If summoned early, when the dermatitis has only partially developed, very much can be done for the patient by promptly and effectually rendering aseptic those adjacent parts which the poison has not yet invaded. If any one susceptible to the effects of Rhus poisoning even suspect that he may have been infected or if he actually has been in contact with the poisonous plant, he should quickly take the precaution to bathe those parts of the body which have been exposed, with a fifty to seventy per cent. solution of alcohol. This is imperative, because the poisonous oil, not being soluble in water, cannot be washed off by water alone. Instant washing with the alcohol solution dissolves the oil before it has time to affect the skin. The removal of the oil may also be successfully accomplished with the free application of ether.

If there be no alcohol near by, use a handful of good moist earth and rub it well into the parts—the soil being alkaline neutralizes the acidity of the oil. If no other means be available, wash faithfully in a thick lather of a good strong soap and water. To neutralize, probably nothing is better than a saturated solution of epsom salts which should be applied freely and bountifully.

Remember that the hands are very often the parts which come in contact with the plant and whatever portions of the body the hands touch immediately become infected and poisoned. If the hands be affected, it is literally and truthfully a case of “HANDS OFF,” *from every part of the body*; for wherever the hands touch, the poison will be planted to do its fiendish work.

*Symptoms.*—The period of incubation is from four or five hours to as many days. The first symptoms, or notes of warning, of Rhus poisoning are an itching, burning, crawling sensation over a part or all of the body, which has been described



as thousands of fleas traveling and biting all at the same time; usually a smooth, red rash appears which is followed by blisters, large or small, or both. Wherever the skin has been touched by the plant it becomes swollen, slightly painful, burns and itches furiously; small water-filled blisters arise which appear in a chain showing the line of contact with the poison. If the attack be due to pollen or smoke, all the affected part shows extensive swelling but the little blisters are visible only through a magnifying glass. The itching increases as the vesicles appear and rubbing them causes the blisters to break; a watery substance exudes which soon dries and forms a crust. Great care must be taken to keep diseased parts "surgically clean" because serious results may ensue if they become infected with pus producing organisms.

If the face be affected there is swelling of the lips, ears, cheeks and nose and then pale, puffy swelling of face; later with burning pain in the face, eye lids closed by swelling, lachrymation, intense burning itching, face covered with vesicles full of yellow water. This typical condition will be anywhere and everywhere over the body which has been touched by the poison.

The toxic effects of a Rhus poisoning may be carried so far as to cause a full proving of the pathogenesis of the drug—including diarrhœa, the characteristic backache, drowsiness or great nervous restlessness, chills, delirium, fever (of typhoidal character) unconsciousness, paralysis, etc.

It is untrue that the symptoms of a Rhus poisoning return annually as a result of previous infection. On the contrary, when the vicious effect of one attack has been cured or has run itself out, *there is no recurrence until a fresh infection occurs.*

*Treatment, External.*—The chief thing is PROMPTNESS; promptness on part of the patient to obtain a doctor and promptness on part of the doctor to "get busy" with his patient. The old adage, "A stitch in time saves nine," may be paraphrased by "An alcoholic application in time saves days of suffering." (See above, "Prevention.")

☞ If one can cleanse the oil from the body *quickly* with ether or with a 70 per cent. solution of alcohol and then neutralize the remaining poison that will not come out of the skin, the resultant dermatitis is trifling. Recognition of this all-im-



FIG. 6.—Poison Ivy is trifoliate with waxy white berries. (See above.) Virginia Creeper is five-leaved with blue-black berries.



FIG. 5.—*Rhus venenata* (vernix).

portant factor is too often omitted by physicians and the resultant general dermatitis is generally their fault.

Dr. O. S. Haines writes me: "If I can see a case of Rhus poisoning soon after the blisters begin to form, I think I can stop it; a bath tub—plenty of strong soap and water, plenty of alcohol and plenty of some neutralizing solution like saturated solution of magnesium sulphate" (Epsom salts). This treatment would be still better inside of three hours after infection, *before the blisters begin to form*.

A good method of application is to use large thick folds of gauze, from ten to fifteen, covered by oiled paper or silk, and a layer of cotton held snugly in place by a roller bandage. This dressing of magnesium sulphate, either hot or cold, should be kept thoroughly soaked by pouring the solution into the dressing at least once an hour and not removed before twelve hours have passed. Some failures have occurred because the dressings were not large enough to cover sufficient surface. The layer of cotton may extend over the entire face if desired; the magnesium sulphate (epsom salts) being non-toxic does not seem to affect the eyes in any manner.

Of the many methods of local treatment, perhaps the most common and best known is the *sugar of lead*. To a fifty per cent. solution of alcohol, add as much powdered sugar of lead as is easily dissolved. This solution thoroughly applied to the affected skin several times daily for several days, dries up the vesicles, soothes the itching, cools the parts and prevents further spreading of the poisonous oil.

I recently read in a Hunting book of the curing of a case of poison ivy with whisky. The victim, having come in contact with the plant while fishing, says: "During the night I had awakened with a curious sensation about one of my eyes. There was a slight irritant, itching tendency and the flesh felt puffy to the touch. I tried to believe it was imagination and went to sleep again. But there was no doubt next morning—it was poison ivy and I had it bad; face puffed up out of recognition, eyes closed, etc. I had an inspiration; alcohol cures it, maybe whisky will. We remained two days in that camp and I followed up the whisky treatment faithfully—the whisky treatment was a success! Many times a day I bathed my face in the pure waters of the lake and then with the spirits—rye or Scotch as happened to be handy. By the afternoon of the first day I could see to put sirup on my flapjacks; by the next morn-





FIG. 7.—The dainty seeds of the poison ivy are similar to the berries of the sumac; the sumac berries, however, hang from individual stems. In poison ivy they form clusters as shown here.



FIG. 8.—A typical illustration of the common roadside Poison Ivy, showing the late summer characteristics of *R. toxicodendron* with its well developed fruit.

ing I felt able to travel. Alcohol, of course, is good for poison ivy, but whisky is better."

According to the *Medical Review of Reviews* permanganate of potash is effective in the local treatment of Rhus poisoning:

"Recent studies have demonstrated the cause of the irritation and it is now known that the irritating agent may be neutralized by *permanganate of potash solution*. The application of the permanganate solution gives great relief and when used soon after exposure or as soon as the first vesicles appear will avert the distressing itching. Treatment should be as follows: First thoroughly wash the part or parts with warm water and soap; then use an alkaline wash, as for example a teaspoonful of bicarbonate of soda to one pint of water. Following this should come several washings in warm 2 per cent. to 4 per cent. solution of permanganate of potash. The strength of the permanganate solution should vary according to the severity of the attack."

Dr. Carmichael tells me: "Occasionally I have supplemented the internal remedy with applications of ammonium chloride (sal ammoniac), a one and a half per cent. solution. In a dermatitis from a cause without the body I have no hesitation in employing an external application."

*Hydrogen peroxide* has been recommended for use as follows: Apply *Marchand's* solution, 15 vol., full strength, about four times a day, wetting thoroughly; after three or four minutes, if it is "biting" too strongly, wash with a little cold water—splashing, not rubbing; then dry to dampness but not wholly dry; after two applications good results are apparent, the swelling and inflammation disappearing, etc.

*Sodium*, in various forms is largely used to neutralize Rhus poison. A solution of carbonate of soda (washing soda) one teaspoonful to a quart of water may be freely applied.

The photographers' "*Hypo*" (sodium hyposulphite), called "thiosulphate" by chemists, is very generally employed as an antidote, applied externally as a wash, same solution as used in hardening or "setting" plates. It comes in pound packages.

Hartshorn, i. e., household ammonia, found in every well appointed household, is an effective neutralizer to the Rhus poison oil. It should be diluted one part hartshorn with two parts water and then applied freely.

*Aristol powder* thoroughly dusted in has proved an excellent dry treatment and is often useful.



Other palliative remedies recommended are succus *calendula* (not the tincture). Very strong salt baths. *Alum*, powdered or in solution, is claimed to render efficient aid in healing the Rhus dermatitis and allaying the burning and itching.

*Treatment, Internal*: An infallible rule in Rhus poisoning is: "The sooner the physician is summoned, *the better (and cheaper) for the patient*," because, as described above, he can very often practically check the infection; and can always alleviate the sufferings which unrelieved would greatly increase in severity and in their extent over the body.

Too often, however, the medical man does not see his case until it has progressed beyond control. It is then that the competent prescriber, with a masterly hand, concentrates and unites all the symptoms into the much-needed "simillimum" the administration of which causes welcome relief.

A few remedies appear, symptomatically, to be more frequently indicated than others but it must be remembered by the conscientious practitioner that any remedy in the *materia medica* may be necessary to complete a cure by wholly removing some ill effects of the poisoning lingering in the system, after the acute attack has passed by; also, an unusual remedy may be needed to treat successfully an infection which has just begun.

In one of my cases the administration of arsenicum at the beginning of an attack was immediately followed by a complete cure of the patient's symptoms; in another, some lingering dregs of the attack were promptly and permanently removed by a few doses of *pulsatilla*.

Of course the "simillimum" to the totality of the symptoms must be obtained in every case to cure "*in a mild, prompt, durable manner*." Among the many considerations conspiring to form the "simillimum," the character of the dermatitis together with its predominant sensations, form an integral portion in the mind of the prescriber. Is the eruption itching or burning; dry or moist; painful, throbbing, swollen; red, purple, pale; is it in the early stage when vesicular or in a later stage and has become pustular or at the end when it is dried up and scaly?

Many well known constitutional symptoms, characteristic of certain familiar drugs, are often present and greatly facilitate the choice of the remedy.

It is not difficult for a *materia medicist* to prescribe remedies whose symptoms are most similar to Rhus dermatitis



and in a routine practice this information is generally sufficient. It is a help, of course, but it does not go far enough. To the genuine prescriber who seeks the *totality of the symptoms*, things are different. He, too, wants the appearance and sensations of the eruption but he also must have the symptoms of the whole individual. He knows that according to *Hahnemann's Organon*, Sec. 153, "we ought to be particularly and almost exclusively attentive to the symptoms that are *striking, singular, extraordinary, and peculiar* (characteristic); *for it is to these latter that similar symptoms, from among those created by the medicine, ought to correspond*, in order to constitute it the remedy most suitable to the cure."

It is well known that many of the most brilliant cures on record have been due to the recognition of "characteristic" symptoms which appeared in the patient far away from and apparently wholly unconnected with the immediate cause of trouble..

A review of medical literature upon Rhus poisoning shows the following remedies, among others, to have been used with good effect: *Agaricus, anacardium, apis, arnica, arsenicum, bryonia, croton tiglium, euphorbium, graphites, indium, ledum, nitri-spiritus-dulci, nymphaea, pulsatilla, rhus tox., rhus venenata, sanguinaria, sepia, sulphur, verben.*

*Anacardium*.—Large, watery blisters on an inflamed base with swelling of the various joints. Also, see Hering's Guiding Symptoms, "Skin."

*Apis*.—This remedy is recommended by some authorities to be given "very low"; others say to give it "very high." Is claimed by many to be the best of all remedies to cure Rhus poisoning—being indicated in the acute stage, large vesicular eruption, etc., also in late stage.

*Belladonna*.—Where fever is excessive.

*Bryonia*.—Yields marvelous results in many cases in alleviating the unbearable itching.

*Croton Tiglium*.—Very fine, small, vesicular rash; small boils; in the pustular stage.

*Dulcamara*.—Bronchial and nasal symptoms.

*Euphorbium*.—Vesicles very large.

*Euphrasia*.—Indicated for conjunctivitis, lachrymation, etc.

*Rhus Tox.*—Regarded by very many authorities as most efficacious in the first symptoms of Rhus poison—given in high potency.

*Sanguinaria*.—In the vesicular stage.

**SUGGESTIONS TO THE GENERAL PRACTITIONER CONCERNING THE  
SUBJECT OF ACUTE MIDDLE EAR SUPPURATION.**

BY

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(Read before the West Jersey Homœopathic Medical Society.)

THE subject of acute middle ear suppuration is too big for one to attempt to cover thoroughly in a single short paper; accordingly, my efforts shall be to refer to those points which appeal to me as the more important. Acute middle ear suppuration is more prevalent in the winter and early spring than during the summer and fall, because the actuating cause—the acute specific infections, especially tonsillitis, scarlatina, measles and influenza—is more prevalent then. So far this year we have witnessed more than the usual number of such cases, which affords sufficient reason for presenting the subject at this time.

The causes of acute middle ear suppuration may be practically narrowed down to two: (a) the presence of pathologic adenoids and tonsils as a predisposing factor; (b) the spreading of an acute infection (bacteria) from the nose and throat to the Eustachian tube and middle ear.

The presence of adenoids plus a simple “cold in the head” (a relatively mild infection) is prone to result in the milder forms of acute middle ear *catarrh*; while the presence of adenoids plus a severe surface spreading infection, such as is met with particularly in measles, scarlet fever and influenza, is prone to result in acute middle ear *suppuration*.

Repeated attacks of earache or deafness, even though slight, should be the signal to treat the adenoids in our efforts to thwart an eventual middle ear suppuration. I do not wish to infer that the absence of adenoids is a guarantee against an attack of scarlatinous middle ear suppuration, but I do hold that the possibility is decidedly less in those without than in those with adenoids.

You may recall the fact that the inferior end of the Eustachian tube, the so-called trumpet, protrudes into the nasopharynx from the side. Nature has thus constructed it to prevent discharges and infectious materials from getting into it readily as might occur if it was flush with the surface. The presence of enlarged adenoids so pads the pharyngeal walls as

to produce an artificial condition where the Eustachian tube orifice is practically submerged and in some cases entirely covered by the adenoid overgrowth. In the event of a violent infection, where the diseased adenoids become a hotbed for the bacteria, you can readily understand the ease with which the Eustachian tube may become infected. The resulting inflammation of the Eustachian tube closes it, leading to a negative pressure within the closed spaces of the middle ear.

During the progressive stage of an acute infectious disease, the inflammation of the mucous membrane spreads more or less rapidly in all directions, giving rise to congestion, which manifests itself by increased redness and thickening of the mucous membrane; to infiltration, of small round cells, even to the deeper layers of the mucous membrane; to increased and altered secretion, containing mucous, serum, leucocytes and degenerated epithelium (muco-pus). After the infection has lasted a definite period, the human organism reacts by producing substances that resist the infection; when there begins the subsiding stage of the disease.

The earlier the invasion of the Eustachian tube and middle ear occurs, in the course of the infectious diseases, the more pronounced the changes will be. Furthermore, in an individual with a previously lowered vitality the infection spreads more rapidly and the reaction is less prompt and weaker than in normal individuals; consequently, the Eustachian tube remains closed for a relatively longer time. The constantly accumulating discharges lead to increased pressure within the cavity and softening of the tissues, especially of the more yielding tympanic membrane, resulting in spontaneous rupture and discharge of pus with relief of symptoms.

Fortunately, not every case of infection of the middle ear terminates in rupture of the tympanic membrane; for in those patients, who are more resistant than the average the Eustachian tube swelling diminishes early enough to permit of free drainage before the suppuration of the middle ear has advanced to any great extent—abortive cases.

What I wish to emphasize is that the extent and intensity of the suppuration of the tympanic cavity is due, not alone to the intensity of the bacterial invasion; but, too, to the length of time that the Eustachian tube remains closed. Similarly, we may refer to the mastoid cells. When the gateway between the tympanic cavity and mastoid cells (the so-called aditus ad an-



trum) is closed for a considerable length of time the secretion in the cells, which is always more or less present in cases of acute middle ear suppuration, not finding an exit into the middle ear cavity, becomes confined and under increased pressure causes devitalization of the muco-periosteum, resulting in mastoid empyema.

After having considered briefly the pathology and course of acute middle ear suppuration, what might we expect to find among the symptoms: (a) *Fever*, with the temperature ranging somewhere between  $99\frac{1}{2}$  and  $103\frac{1}{2}$ . This symptom may be due to the toxemia of the general infection, when we would expect to find it relatively high or to the local infection of the ear, when we would be more likely to find it relatively low, or perhaps to both causes. (b) *Headache together with the so-called general malaise*. This is likewise due to the toxemia. Its intensity depending upon the extent of the toxemia. (c) *Restlessness* and perhaps *convulsions* among the younger infants due to the same causes as the preceding.

The above form a group of general symptoms, which taken alone mean nothing, since they are met with in almost any inflammatory condition elsewhere.

We come now to the more special symptoms of acute middle ear suppuration.

(d) *Pain* in and about the ear (earache); this symptom is constantly present, but may be overlooked in very young children. Older individuals assert that the pain is more intense in the ear, but is evident even behind the ear. The pain is characteristically worse at night, when the patient is lying down. This fact can be appreciated when you recall that inflamed parts are generally more painful when depressed than when elevated. Ask anyone who has suffered with a felon! The pain in the ear usually endures until drainage has been established either through the Eustachian tube or the external auditory canal by way of a perforation of the drum membrane.

(e) *Tenderness* about the ear and even over the mastoid process is a symptom usually found in acute middle ear suppuration; however, when it occurs late, it points more often to mastoid suppuration. I might add that tenderness of the ear to pressure on the tragus points to disease of the external canal, especially furunculosis and not to middle ear involvement.

(f) *Impairment of hearing* is a constant finding. The degree of which varies considerably in different individuals. As

a suggestion for the differential diagnosis, I wish to say that the diminution of hearing in middle ear suppuration is greater than in cases of boils of the canal (the disease most commonly confused with middle ear suppuration). The impairment of hearing is of the type characteristic of diseases of the conducting apparatus, i. e., diminution of air conduction and increase of bone conduction.

(g) *Subjective noises in the affected ear* or tinnitus is a less constant symptom than those already enumerated. Its presence or absence will not help the general practitioner in the diagnosis; aside from the fact that the presence of tinnitus speaks for a more violent inflammation than its absence.

(h) *Dizziness* of the characteristic aural type may or may not be found, and what I have said concerning tinnitus applies with equal force to this symptom. Both symptoms point to some affection of the ear, the character of which must be determined by very careful analysis—the work of the specialist.

(i) *Otorrhoea* or discharge from the external ear occurs only after spontaneous rupture or a paracentesis. At first scant, bloody and thin, gradually changing to a profuse mucopus or pure pus. The character of the discharge, its consistency and odor, depend also upon the character of the invading micro-organism, upon secondary changes in the pus and too upon the complication of the middle ear affection, for instance; in case of necrosis we find the characteristic gritty discharge with color dark and the peculiar cadaverous odor. When the discharge follows promptly after the earache has begun, say within 8 or 10 hours, it is safe to conclude that the membrane was thin; in other words, that the present attack was not the first. An ear discharge which appears, only, after several days of pain, speaks for the first attack of suppuration.

Concerning the subject of otorrhoea, I would like to speak of something of importance, to wit: The presence of a violent middle ear suppuration going on to great destruction of the neighboring parts without rupture of the membrane. I have seen three such cases this winter which came to operation. The destruction of bone was very pronounced in all. In spite of this contrary finding it is possible to make an accurate diagnosis by otoscopic examination to which I shall refer below.

By otoscopic examination, we find:

(j) *The membrane red and bulging* with the anatomical details quite indistinct. The bulging of the membrane is more

pronounced in one or the other of the four quadrants. This bulging may be likened to the pointing of an abscess. If the ear had been previously treated with local applications of carbolic acid, chloroform or other similarly acting remedies, we find the mascerated epidermis which may mask the more typical picture described above.

After rupture of the membrane, we find:

(k) A *perforation*, at first small, but later increasing in size according to the intensity and duration of the suppurative process. The two most favored locations for perforation are the lower anterior and the upper posterior quadrants of the membrane. In those cases where the membrane for some reason or another does not rupture in spite of severe middle ear suppuration referred to above, it will be noted that the *membrane appears gray, opaque and lustreless*.

TREATMENT may be directed toward (a) the prevention of the disease and (b) toward the cure, after the disease has actually begun.

Prevention consists in the removal of the causes, as far as possible, by *treating enlarged or diseased adenoids and tonsils* whenever found and by *careful isolation of all patients suffering from any of the acute specific infections*.

The curative treatment of acute middle ear suppuration should include at least the following:

*The treatment of adenoids:* Some authors go so far as to attempt removal of the adenoids during the attack of middle ear suppuration. We are warranted in at least treating the mouth of the Eustachian tube with shrinking solutions in our efforts to open it and thus favor drainage.

*The treatment of the primary infection:*

After the middle ear inflammation has reached the point where pain is a marked symptom, *heat* in some form should be applied to the region of the ear. Avoid, however, the use of anodynes as they are usually more irritating than anodyne in their effect. Furthermore, by the time the patient needs anodynes the case is ready for a paracentesis. Early *paracentesis* is the best guarantee against complicating mastoiditis.

After spontaneous rupture of the membrane or the operation of paracentesis, *drainage* should be favored with wide mesh, sterile gauze applied as a wick in the canal, one end of which should reach the perforation. These should be changed as frequently as necessary to prevent the canal from becoming



soaked with the secretions. In some cases hourly, in others once or twice daily depending upon the amount of discharge.

Little is to be expected from attempts at lavage of the tympanic cavity, for in the acute cases, the perforation is so small that the injected water does not reach the cavity. The most we may expect to do is to keep the canal clean. For this purpose sterile water is better than antiseptic solutions. Solutions to be antiseptic must be more or less irritating to the skin of the canal and may cause a dermatitis with consequent narrowing of the lumen of the canal, which if pronounced, may interfere with proper drainage. I have known this to occur else I should not mention it.

In cases that progress favorably, it will be noted that bubbles occur in the secretion. This speaks for beginning patulousness of the previously closed Eustachian tube and calls for the use of inflation. *Inflation* after the Politzer method may be practiced from then on at varying intervals, according to the amount and character of the secretion. Previous to this time inflation is useless. Inflation should be discontinued the moment the secretion ceases; for, its continued use, thereafter, is unfavorable to the closure of the perforation.

Now as to the use of peroxide of hydrogen so commonly in use, I wish to say that there is little or no need for it in these acute cases, for the reason that the opening in the membrane is generally very minute and the solution does not reach the parts for which it was intended. In cases of longer standing and with larger perforations, its use may be commended.

Concerning the internal remedies to be used, I have only to say, use anything which seems to suit best the totality of the symptoms. Apropos of the subject of remedies, I am reminded of what occurred at a meeting of a society similar to this, where I had the honor to present a paper. At the conclusion of my paper, one of the members arose and said: "Your talk is all right, but you are like the rest of the fellows that are sent here from Philadelphia. You tell us all about the disease and never tell us the remedies. What we want to know is how to cure our cases." My reply was that homœopathy knew no specifics and that a good homœopath prescribed on the totality of symptoms, and for one to limit himself empirically to a certain set of internal remedies was unhomœopathic. Therefore, I would advise that you give the indicated remedy, no matter what it may be, even though no one has ever thought of it before in connection with acute middle ear suppuration.

**CLINICAL THERAPEUTICS.**

BY

DR. O. H. PAXSON, M. D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of the County of Philadelphia.)

IN discussing this subject, it is my intention to-night to call your attention to the important relation it bears to the whole field of medicine, and especially to homœopathic therapeutics. In the past few years, as we all may know, there have been many changes in the methods of teaching in the various medical colleges of the country and especially along the lines of clinical teaching. This has been very noticeable in the Hahnemann Medical College in all of the departments into which the curriculum is divided. The subject of clinical therapeutics is one of the steps in this field. Our Dean, Dr. Wm. B. VanLennep, is entitled to the credit for this division of therapeutics. One year ago it was begun with sectional classes of the senior students in periods of ten weeks in the medical wards of the Hahnemann Hospital.

It must be evident to all that this subject, as planned at present can be made the most important subject of the whole curriculum. It is the life-blood that should animate and vitalize all of the special departments of medicine as it does the department of general medicine. Surgery, too, could make use of its assisting hand.

As at present taught, great importance is to be given to symptomatology, both subjective and objective. The time was when the great mass of symptoms for guiding the homœopathic physician in his selection of a remedy were the subjective symptoms; to-day we are including the objective ones as well. This is the time for our college to march forward and claim the various objective symptoms as a valuable aid in prescribing the homœopathic remedy. Physical signs, as objective symptoms, belong as much to our *Materia Medica* as do the subjective symptoms.

The use of objective symptoms in the selection of a homœopathic remedy is not a new thought. Hahnemann advocated it in his writings and it is but fair to assume that he, if living, would include in the objective symptoms of patients and provers, the physical signs and laboratory findings that so enrich our knowledge of disease at the present day. That it was not

so included by Hahnemann it needs but for me to point out to you that in his day much of it was unknown. It is not fair that this rich field of knowledge should be monopolized by the diagnostician and the pathologist. The workers in this field have done a wonderful work, but there is a greater one before them if they but knew it and that is to incorporate the results of their thought and study into the symptomatology of our *Materia Medica*, and instead of it being only an evidence of disease, make it become the means of curing a disease.

It is not for us to require that drugs shall produce physical signs and laboratory findings, it is enough that we determine that these objective symptoms belong to certain drugs. In Hahnemann's time diseases were treated successfully regardless of their bacteriological nature. We, in our day, should go a step further and by the addition of this scientific knowledge to our *Materia Medica* be still more successful.

To those who would object to this method of addition to the *Materia Medica* of Hahnemann, I would ask of them how much of the present symptomatology belongs to actual effects of drugs and how much to clinical evidence? For instance, if with the use of a certain remedy a case of diphtheria recovers, and following the recovery the symptoms of that case are accepted as indications for its selection in a similar case is it not as legitimate to add the objective symptoms as it is to add the subjective ones?

As an illustration, if this was done and accepted as I ask above, quinine would be wisely used where *plasmodium malariae* are present, and would not be abused, although other symptoms were similar, in such foolish prescriptions as quinine and whiskey for a bronchitis.

Clinical therapeutics should not be limited to the field of general medicine but should include all of the departments of medicine, as the eye, the ear, the nose, the throat and stomach specialties, surgical cases, gynecological cases, obstetrical cases. My thought is that internal medicine and other treatment should go hand-in-hand with these various specialists; that operative cases could be assisted with internal medicine both before and after an operation.

If you gentlemen who are specializing in your professional work are sincere in your desire to see homœopathic therapeutics become the most successful method of internal medication; to become the foremost method of curing the sick, it is



your duty to assist in this work by using it freely and giving it due credit for the results obtained. I do not believe it is fair to ask the general practitioners of our school to be the only ones responsible for the success or failure of homœopathy. Does it not behoove all of you gentlemen, you who are so skillful in your special work, so enthusiastic in keeping abreast of the most successful methods of curing the sick, does it not, I say, require of you equal enthusiasm for homœopathic therapeutics?

For instance what an impetus it would give to the members of our profession if within a short time there should be issued a text book upon surgery, upon gynecology, upon obstetrics, etc., in which equal attention was given to therapeutics as to operative procedures.

To be successful, a truth or law, like humanity, needs to be born and reborn. You all know we have the men with the ability to do this work; let us urge it upon them, and promise them our hearty co-operation. I do not know how many copies of a book are needed to make a successful edition, but I believe that several thousand copies of them could be sold by subscription in advance if such a plan was begun now.

With all of this in mind the present class of seniors are about to enter upon a course of ward teaching in clinical therapeutics under my direction. The first hour of the ward work is given to written work. In this hour each student visits the patients assigned to him. Beginning with a new case he is required to arrange the symptoms, subjective and objective, in two parallel columns. In each column these symptoms are arranged in groups, each group including certain viscera, etc. The groups are as follows: Circulatory, alimentary, nervous, genito-urinary, respiratory, glandular and lymphatic, motor, and external manifestations. The symptoms pointing to the principal trouble are recorded first and the other symptoms follow according to their importance.

In this manner the symptoms of each system, subjective and objective are in parallel columns and are thus associated together for the study of the treatment which is arranged in a third and parallel column.

The treatment comprises, first the homœopathic or dynamic remedy; second, the mechanical; third the dietetic, and fourth the climatic.

The first group of symptoms we consider of the most im-

portance in the selection of the dynamic remedy; the following groups of symptoms enabling the differentiation of the several remedies suggested by the first group. Thus each group of symptoms will contribute its quota towards the totality of symptoms, in their order of importance, and so lead to the selection of the one remedy. The mechanical, dietetic, and climatic treatment, with the diagnosis as a guide, is next considered. It is to be understood that each case has been carefully and thoroughly studied previously with Doctors Golden and Wells as to the physical signs and a diagnosis agreed upon. Where drugs are indicated in the sense of mechanical treatment, their use is so considered and their discontinuance advised as soon as the emergency is passed. The homœopathic remedy may be recommended to be continued or stopped while such mechanical treatment is being carried out.

The treatment as suggested must have the authority of a recognized text book as recommended in the College Announcement under the Department of Materia Medica and Medicine, the book and the page number being a part of the written record.

I am convinced that one way to have good practitioners of medicine is to have men who can confer with an author by means of his written opinions, rather than to have men who have memorized this matter. Like a good lawyer, who refers to certain statutes covering the points he wishes to make, the doctor should be able to refer to his books and so gain the assistance of one who, if present, and talking with him would give him invaluable advice.

With a record as outlined above, the sectional class meets their instructor at the patient's bedside, and for more than an hour confer with him as to the therapeutic measures for the individual cases before them. In such a conference the same consideration is given to the treatment of the attending physicians, Doctors Haines and Bartlett, as if they were present, and in conclusion, if any change in the treatment is thought advisable it is requested in writing, care being taken to have it expressed in correct form and language.

The attending physician receives and acts upon these suggestions as he deems best, accepting them or returning them with his objections. The resident physician and a senior nurse accompanies each conference to answer questions and

give information as to the case under consideration. The presence of the resident physician and a nurse encourages a certain attitude of courtesy that should be learned before leaving college and that too often in the past has been acquired by some only after years of work.

It seems to me that such a class of students might be termed a consultation class, meaning by this that these men are acquiring by this method of study the ability, not only to prescribe accurately but to enable them to carefully consider these important problems in the manner that a consulting physician does.

We have the material; it is our duty to produce the results.

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### **MANNKOPF'S SIGN---ITS VALUE IN DIAGNOSIS.**

BY

CHARLES LEE BAILEY, M. D., ALBANY, N. Y.

(Read before the New York State Homœopathic Society, Albany, N. Y., Feb. 11-12.)

I WAS once asked on the witness stand how I knew that a certain person was suffering pain, and undoubtedly many of you gentlemen here have at times wondered—is this patient suffering pain, or is it a hypercitation of his nervous system? In Mannkopf's sign we have a valuable aid in diagnosis, and when technic is perfect, we can positively say that our patient is suffering pain or not.

The first question that confronts us is, "What is Mannkopf's sign?" If we make firm pressure over the area which the patient says is painful, and there is inflammation sufficient to produce pain, there will be during the time we are pressing over the painful area an acceleration of pulse beat of from 10 to 30 per minute.

In functional diseases, we at times have an acceleration of heart beat, but in organic diseases pressure over painful areas will as a rule increase the pulse beat.

I have had quite a large experience in the examination of litigants, and I have examined men who were fakirs, and I have examined men who were suffering from some organic disease of the nervous system. It is true that during a trial, or



previous to a trial of a case, a person's nervous system is usually hyper-sensitive, his eagerness to win his suit has a great tendency to increase the pulse beat, and when the suit has been either lost or won, and the final decision has been given by the court of last resort, we have positive evidence whether the patient was suffering from some organic disease or if he was faking.

The past summer I spent the month of August taking a post-graduate course at the University of Edinburgh, Scotland. Each morning we had two sessions of nervous diseases, and during the intermission, I usually stepped into the surgical clinic held in the Royal Infirmary.

One morning, a patient was brought before the clinic, and the history given intensified my belief in the value of Mannkopf's sign. The patient was a woman 34 years of age, married, wife of miner. She had three children, four miscarriages, and in all these miscarriages they happened at the seventh month. Wassermann's reaction proved that she was not syphilitic. Her history was as follows:

For some time she had complained of an intense pain in the iliac fossa, femur somewhat reflexed, temperature ranging from 100 to 101 degrees, suffering severe pain, abdominal muscles rigid. A diagnosis of appendicitis was made, and an operation performed, and the appendix removed. The woman left the infirmary after two weeks apparently cured. In two or three months, she presented herself again at the clinic, still suffering pain in the right iliac fossa, loss of appetite, headache, and at times vomiting immediately after eating, exceedingly nervous and irritable. The area in the right iliac fossa was very sensitive, that even the weight of the bed clothes was intolerable. Sedatives were given, and she was sent on her way. She returned within a few days still complaining of pain, when a diagnosis of enteroptosis was given and an abdominal bandage was prescribed to try to keep the abdominal viscera in proper position. She returned in a few days still suffering pain, no relief from remedies or from bandage, which was prescribed, and it became general talk that she loved to be examined and lectured about, and that she was suffering from hysteria.

This history was given one morning when I visited this clinic and before the patient was brought before the class. When she was brought in the interne, while making a deep pressure over the right iliac fossa called the attention of the sur-

geon to the acceleration in the heart beat. The surgeon examined the patient, keeping his finger on her right radial, and had her removed to the waiting room to be brought in at a later hour during the clinic. She was brought in during the afternoon and again examined. Pressure revealed a perceptible acceleration of heart beat, and it was such that the surgeon decided to make an abdominal exploring incision, irrespective of the previous operation for appendicitis, basing his opinion upon the degree of acceleration of the heart beat, when he had made deep pressure over the right iliac fossa.

She was prepared for operation the next morning, brought before the class, and an abdominal incision was made. It was then discovered for the first time that she was suffering from Lane's kink of the ileum. The patient, undoubtedly, when operated on for appendicitis was suffering from Lane's kink. I endeavored to obtain a history of the operation for appendicitis, but was unsuccessful. In many cases of spinal trouble, when we are at times skeptical about our patient suffering from any pathological lesion, if we will make deep pressure over the complained area, the degree of acceleration of the pulse will invariably prove that our patient is not hysterical, but is suffering from a pathological condition. We are too quick at times to arrive at a conclusion, and we are bound to give our patient our best services, and the benefit of every test in order that we may give clear opinion regarding their condition.

My experience has been such that I believe in obscure cases before we put our patients in a hysterical class, if we would only be more careful and be ever on the look-out for Mannkopf's sign, the true pathological condition of our patient would be discovered. I firmly believe in the efficiency of Mannkopf's sign.

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CACTUS AND CACTIN.—Having tried it on frogs and dogs with no effect, some nonpracticing authors of works on therapeutics concluded that the fluid extract of cactus, or cactin, is therapeutically inactive with human beings. In this stand they find themselves opposed by many practitioners of wide experience. No less a physician than Sir Clifford (Saunders' "Hand book of Practical Treatment," 1911) has found cactus the best remedy for the irritable symptoms of functional heart disease, and very useful in convalescence from heart strain by effort. The dose of the fluid extract of cactus is about 15 drops.—*Editorial from The Denver Medical Times for September, 1912.*

**Transactions of the Homoeopathic Medical Society  
of the State of Pennsylvania.**

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**BUREAU OF GYNECOLOGY**

**W. A. STEWART, M. D., Chairman**

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**SOME POINTS IN PATHOLOGY OF PRACTICAL VALUE TO THE CLINICAL  
GYNAECOLOGIST.**

BY

NORMAN S. BETTS, M. D., PHILADELPHIA.

THAT an understanding of pathology is one of the great fundamental principles of all forms of therapeutics will perhaps admit of no argument. It is the object of this paper, which is based upon eight years of almost daily work in the pathology of the female genitalia, to review some of the points in this field which may be of practical value to the clinical gynaecologist, as well as to the general practitioner in his office diagnostic or minor surgical work.

The vulvar mucosa is the site of a number of pathological lesions of clinical interest. The common urethral caruncle is not frequently the site of carcinoma, but its macroscopic appearance may closely simulate malignancy and render a microscopic examination advisable upon its removal. The histology of the tissue here is peculiar from the fact that the epithelium lining the urethral glands and occasionally even the urethral lumen while being cylindrical in type is often heaped up to several layers in thickness. Microscopic sections of inflamed urethral caruncles often give a picture strikingly suggesting malignancy, with apparent proliferating nests of epithelium, though the tumor is absolutely benign. An otherwise good pathologist, who is unfamiliar with these structures, will readily make mistakes in the diagnosis of suspicious caruncles. Do not be satisfied with a diagnosis of malignancy, unless you are sure the pathologist is familiar with this field.

A caruncle or vascular polyp is differentiated clinically from prolapse of the urethral mucous membrane and condylomata acuminata by its extreme sensitiveness.



In the treatment of gonorrhea in the female, the orifices of Skenes' glands should always be noted for the presence of expressible discharge. Remember that these ducts open just as frequently outside the urethra as within its lumen. We may find the orifices in the vulvar mucosa a full centimeter from the external urinary meatus. A deeper pigmentation along their linear margins usually means an old, possibly cured, infection.

The rather slow growth and correspondingly better prognosis in many cases of carcinoma of the vulva when thorough surgical treatment is instituted before the growths are too far advanced should stimulate us to early diagnosis and treatment. Carcinoma involving the vestibule does not usually tend to extend beyond the introitus into the vagina; a pathological point of importance to the operator in planning the scope of his incision.

The painful possibilities of a displaced coccyx or a sprained sacroiliac joint are occasional diagnostic stumbling blocks. If there has been a recent pregnancy or severe fall, a persistent backache simulating that of uterine disease may be due to abnormal relaxation of the sacro-iliac synchondrosis. The pain of a displaced coccyx may at times be referred to the lower back or abdomen and simulate that of abdominal or pelvic disease.

It is ordinarily taught that the epithelium of the vagina is absolutely devoid of glands; that vaginal secretions come from the uterus, or, to a slight extent as a transudation, through the squamous, skin-like epithelium. In the vast majority of cases, this is true; but occasionally true vaginal glands (described by Van Prueschen) lined with high columnar epithelium are found. These structures, as well as glandular remnants of Gartner's duct in the vaginal wall, explain the etiology of some of the cysts and adenomata of the vagina, which are at times encountered.

The majority of so-called erosions of the cervix are not true erosions in the sense of there being here any true loss of substance. In most cases, these angry red areas about the external os are due to a pouting out of the lining of the cervical canal producing what is known as an ectropion. The pouting is due to congestion or lacerations of the cervix or both. The epithelium being but a single layer in thickness allows the underlying blood in the congested tissues to show bright red in comparison with the adjoining areas covered with many layered squamous epithelium. The practical point here is that attempts

to heal such "erosions" are a waste of time. Repeated applications of astringents and stimulants such as alum, silver nitrate, etc., will cause an apparent cure of the condition by stimulating abnormal cell proliferation and consequent thickening of the single layered epithelium lining the cervical canal. An ectropion is, however, a result, not a cause, and the rational treatment is the removal of the exciting factors of the congestion by plastic surgery of the cervix, replacement, curettage, antiphlogistic tampons, douches, etc., depending upon the indications.

It may be of interest to note that in women who have borne children, especially where cervical lacerations have occurred, there is frequently a tendency for the squamous epithelium of the vaginal portion to extend upward into the cervical canal. About three years ago, I examined a specimen showing a squamous cell carcinoma starting from the neighborhood of the internal os. Nearly the whole canal in this case was lined with squamous epithelium.

The comparatively good prognosis in adeno-carcinoma of the body of the uterus when operated early should be sufficient even without other inducements to require a microscopic examination of all curetted material where there is the slightest suspicion of malignancy.

Cancer of the cervical canal offers the worst prognosis, that of the endometrium the best; while growths occurring on the portio vaginalis occupy an intermediate position as regards probability of cure by modern surgery.

There is a rather generally accepted opinion that cancer of the uterus is never present, or is very uncommon, in the negro race. The statistics of the Johns Hopkins Hospital, quoted by Cullen, seem to negative this assertion; the disease in the proportion of white and colored women treated seeming about equal in the two races. I have myself never seen cancer of the portio in a negress, and the late B. F. Betts once told me that in his experience of some thirty years in gynaecology, he had never encountered a case.\*

It is only within the last few years that we have come to understand the constant alterations which are occurring in the endometrium during each so-called menstrual cycle, or period between each menstrual flux. Without attempting to describe these changes, it is worth while to point out that as each mens-

\*Since writing the above I have seen two specimens of carcinoma of the portio in colored women.

trual period approached the endometrium takes on a greater or less degree microscopic characteristics simulating those of early pregnancy. We are constantly seeing almost typical decidua cells in premenstrual endometrium. It illustrates the fallacy of making a positive diagnosis of pregnancy unless some fetal elements can be demonstrated.

We have read a great deal, in recent years, of a class of cases characterized by intractable metorrhagia occurring in women between 35 and 45 years of age in whom cancer and all the usual causes of uterine bleeding can be excluded and which are resistant to curettage and other ordinary therapeutic measures. We can demonstrate quite clearly that the hemorrhage in such cases in the majority of instances is due to muscular degeneration of the myometrium with consequent loss of control of the normal vascular tone of the organ. In some cases, arterio-sclerosis is also a factor. The only practical treatment seems to be hysterectomy.

At a previous State Society meeting, I called attention to the role which dilatation of the veins of the broad ligaments plays in the etiology of many somewhat obscure pelvic pains. Varicocele of the pampiniform plexus is doubtless the cause of much of the backache, feeling of dragging weight and bearing down sensation which accompanies or may be independent of numerous pelvic disorders. Unless phleboliths have formed, it is usually impossible to make a diagnosis by the examining finger.

I cannot leave the subject of uterine pathology without referring to the folly of using the sharp curet in infections of the uterine cavity, especially during the puerperium. A moment's thought by anyone who knows anything of pathology should be sufficient to convince that such treatment can scarcely fail to aggravate the condition by spreading infection through vessels and lymphatics, and by breaking down nature's protective barrier of leukocytic infiltration.

In considering the Fallopian tubes I would refer only to the fact that tuberculosis occurs in these structures more frequently than is perhaps generally supposed. A correct diagnosis has such an important bearing upon prognosis and subsequent post-operative treatment that a microscopic examination is recommended in all cases in which the etiology of the salpingitis is not evident. Williams, quoting the statistics of Johns Hopkins Hospital has stated that eight per cent. of all tubes re-



moved were tubercular and of these only 25 per cent were diagnosable without the use of the microscope.

It may be of interest to refer to the contention of Charles and William Mayo that, when numerous abdominal organs are tubercular, the removal of the organ first infected generally checks or cures the disease in other organs.

The advance in our knowledge of ovarian pathology has kept pace with that of the other genitalia. Goodall, of Montreal, has recently issued a masterful article on the epithelial new growths of the ovary from an embryological and comparative standpoint. He throws some new light on the etiology and reason for the comparative frequency of the benign and malignant tumors of this organ. While the monograph has, as a whole, more of academic than distinctly clinical interest, some of the deductions are of decided practical importance. It is generally taught that sarcoma of the ovary is or becomes so frequently bilateral and the growth is so rapid that removal of both organs is always indicated, even though one may appear normal to the naked eye. The teaching as regards carcinoma has, I believe, been somewhat more liberal as regards conservation of the opposite ovary. In this connection, the statistics of Goodall and those of Kelly are interesting. In the Royal Victoria Hospital of Montreal from 1902 to 1912, Goodall records the following figures:

	Single.	Double.
Carcinoma Ovarii .....	2	15
Malignant Papilliferous Cysts .....	7	22
	—	—
	9	37

In a series of 90 cases operated by Kelly, 33 were double and 57 single.

In the light of such figures, it would seem that in all cases of malignant ovarian disease, the removal of both ovaries is indicated to lessen the danger of recurrence. These organs are peculiarly prone to malignant degeneration, both primary and by metastasis, even from comparatively distant organs. In cancer of the uterus unless in the earliest stages oophorectomy should always be performed.

The wonderful resources and efficiency of modern surgery have been evolved to a great extent from the labors of the

pathological investigator. I would close this paper with a plea for the more careful routine examination of all tissues removed upon the operating table; the benefits will more than repay for the time and labor involved.

#### DISCUSSION.

DR. THEODORE J. GRAMM: I have been pleased to hear this very scholarly paper and especially wish to endorse the last suggestion made by the speaker, namely, that a careful examination be made of all tissue removed at a gynecological operation. In regard to erosions of the cervix, the theory of origin that has been suggested by the writer, is one that has held sway for many years. During the last few years, however, the theory has been advanced that this condition is not an extension creeping along the columnar epithelium from the lining of the cervical canal, but that it is due in many instances to a degenerative change and a distinct disease of the glands of the cervix. It is supposed that the disease in the gland gradually extends downward, finally reaching the cervix and producing this type of erosion. In regard to the writer's suggestion that the myometrial degeneration calls for hysterectomy, I would be inclined to receive that with a certain degree of hesitancy. I believe that many of these cases are amenable to homœopathic treatment. The degenerative changes that take place are not like those in the arteries which produce arteriosclerosis, but are of a senile type. Dr. Betts has called attention to an important fact when he speaks of the use of the curette. We hear too many say "curette until you hear that scraping sound." The fact of the matter is that when the uterus becomes septic you are not in contact with a hard organ, but with one that is easily perforated. A sharp curette should not be used in septic cases. The dull curette is the proper instrument to employ. This should be followed by the irrigation treatment. If you remove the infected material and use proper precaution, the temperature will fall and then as a rule, the patient will recover.

DR. LANE: In regard to the use of the curette in septic conditions, I think we must be careful to differentiate between full time-labor and incomplete abortion. In full-time labor the uterus is supposed to be empty and if we curette we aggravate the case; but in incomplete abortion conditions are different and, I believe, that curettage is the only treatment that will quickly cure these cases.

DR. BETTS: In regard to the myometrial degeneration, I wish to state that in my opinion the vast majority of these

cases are amenable to homœopathic remedies. It is only when all other measures fail that hysterectomy is to be advised. As regards curetting in septic conditions, I am convinced of the value of digital curettage. In every case of abortion it is our duty to explore thoroughly and remove any fragments of placental tissue. The tip of the index finger is well suited for this purpose. I agree with Dr. Gramm that it is folly to use a sharp curette in these cases.

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### **A PLEA FOR A MORE GENERAL USE OF ELECTRICITY IN GYNAECOLOGY.**

BY

ROLAND T. WHITE, M. D., PITTSBURGH.

Is what we define as electricity the ultimate unit of the expression of all force, the alpha and the omega of physical life, the vibratory energy which fills space, controls the constellations and peoples the planets with animal and vegetable life?

These are questions which seem to be nearing an affirmative solution. We have in electricity a valuable aid in the cure of many diseases and in gynaecology especially, a wide field of application which from its relative importance is difficult to abridge into a brief paper even in a plea for its more general use.

I believe in the potential curative, in electro-gynaecology, and electricity reasonably and skillfully used in diseases of the female pelvic organs will restore a goodly percentage of cases, who would otherwise have to undergo operative measures.

I believe the general practitioner, as well as the gynaecologist, should have a practical working knowledge of the physics, physiology and therapeutics of electricity, that the field for its usefulness may be broadened and humanity benefited by its power.

Do we not frequently subject our gynaecological cases to major and minor operative procedures for organic and functional diseases of the uterus and adnexa, which at some time in their development could have been readily and quickly cured by the properly selected and applied electrical modality.

How electricity becomes a remedy—Dr. Massey remarks: "The intimate connection between electricity and physiologic and pathologic processes as being recently considered by Prof.



Dolbear, the eminent physicist, who deprecated all allusion to electricity as a force external to matter and independent of it." Electricity, light, heat and chemic action are inherent properties of matter; electricity being the rotary property of atoms, light the vibratory property, etc.

They are but manifestations of atomic energy which are continuously present in the interchange of atoms in the molecular activities incident to life.

The higher the form of tissue, the greater the amount of energy absorbed in cellular activities.

Until recent years heat was the only physical factor employed for chemic purposes in inorganic processes.

Now, electricity is utilized to produce reactions of great commercial value, e. g., reduction of alumina, making of potassium chlorate and sodium carbonate, and in future may be the instrument in recovering our diminishing compounds of nitrogen.

It would seem logical to conclude that in the selective chemistry of tissues of all kinds, each atom of which having its electro-chemic equivalent, will under conditions of nutritional or cellular derangement be again harmonized and energized by proper electro-chemic influence.

The fluids of the body contain in solution sodium chloride, sodium and potassium sulphate, calcium phosphate, calcium carbonate, magnesium phosphate, potassium chloride, sodium and potassium phosphate, and sodium and potassium carbonate

Electric currents traversing the human tissues largely composed of water holding these salts in solution, must necessarily expend its energy in dissociating molecules from their looser combinations, rendering detached ions "nacent" thus increasing the activity of metabolic processes, which so frequently represent the fault in the disease process. As an illustration of chemic change under the excitation of an electric current taking place in animal tissue. Take for example, the salt potassium chloride, found abundantly in muscle, under the influence of the electric current a recombination of molecules and a physical movement of fluid takes place, viz.,  $KCL + H^2O = HCL + KOH$ , obtaining one molecule of hydrate of potassium and one molecule of hydrochloric acid.

A further illustration of electro-chemic reaction in animal tissue can be followed in chloride of sodium, which represents one half of the mineral salts of the blood; in the following equa-

tion we find  $\text{NaCl} + \text{H}_2\text{O} = \text{HCl} + \text{NaOH}$ . Hydrochloric acid and hydrate of sodium are here produced by the interchange of the molecules of water and salt.

These disintegrations and recombinations of tissue salts in solution are a necessary accompaniment of metabolism and elimination.

So electricity is only an aid to a physiologic process and a wide range of usefulness is apparent in nutritional and functional affections of the uterus and its appendages.

That which may be explained of its chemic action through direct current influence is in a different manner true of other electrical modalities through their sensory motor and counter irritating effects.

The sedative tonic effects of the sinusoidal current observed by the writer following galvanism, which is frequently selected instead of the routine induced current on account of it being without the disagreeable sensory results—can be readily understood if we follow a few of the experiments made some years ago by Dr. Kellogg. After application of the sinusoidal current the sense of fatigue is abolished, following muscular exercise, also muscle power, as shown by dynamometer, is markedly increased.

Correct diagnosis must forever remain the keystone to proper treatment, and any agent or means capable of furnishing assistance in this line are always welcome.

We have in electricity a reliable and accurate agent in the diagnosis and verification of many chronic diseases, through the philosophy of the neuron reflexes and the sympathetic nervous system.

Virchow, in his "Cellular Pathology," gave birth to the idea that every animal appears as a sum of vital units, each of which exhibits in itself all the characteristics belonging to life—not only that, but he maintained the thought that each cell sprang from a preceding or parent cell by division, budding, or otherwise; he believed that the character and unity of life are referable not to any single locality of a higher organization—for example, to the brain of man—but rather to the definite, constant recurring arrangement which every single element bears to itself.

The body, then, is a social organism, in which there is a mass of single existences, related to one another in such a way that every element has its own special activity, and each, when ex-

cited to activity by other parts, does its work and performs its functions of, and by itself.

As the years go by we are able to approach the nervous system with various aids in electrical diagnosis, some of which are capable of giving material service in the precision of observation, simplifying the localizing of the nervous centers involved.

The reaction of degeneration is an expressive procedure in determining the prognosis of paralyzed muscles.

Not so generally known is the influence of the direct current in suppurative pelvic inflammations, giving direct reaction if pus is forming. Electrical diagnosis through the philosophy of the sympathetic reflexes of the spinal nerves manifested by irritability of the vaso-motors supplying the skin capillaries is of more recent development and in passing can be profitably studied in some detail.

No matter how recently an injury has taken place, no matter how long ago or how obscure the symptoms of a chronic ailment may be, as long as some portion or organ of our economy suffers, a reflex center corresponding to that portion or organ will surely be found somewhere in the spinal cord.

Some of these spinal centers are well known; others are more obscure.

The simplicity of the electrical diagnosis will commend itself to you in accuracy and effectiveness.

After the patient's back is bared we apply a high tension induced current in the following manner:

One pole of the coil is attached to a moist electrode five or six inches in diameter and applied over the epigastric region, a smaller electrode from the other pole being well moistened is passed lightly along the spinal column, with a current strength only sufficient to be agreeably felt by the patient. Pass the electrode up and down the entire length of the spinal column with light pressure eight or ten times. On removing the electrode it will be found that we have boldly outlined upon an otherwise white background vivid red spots—these spots for some few minutes after the current is discontinued tend to become even more sharply circumscribed. These points of irritation are surprisingly pathognomonic of reflex ailments which affect the spinal nerves, and the phenomenon is readily explained when we remember the nerve connections just prior to their entrance to, or exit from, the spinal canal, “and bearing in mind



the effect of electric irritation upon any tissue," the conception of why the sympathetic nervous system should respond so readily to our electric irritation before normal tissue can react to the current, is explained in the hyper-sensitive state of these already irritated sympathetic nerves.

To successfully make use of this diagnostic method we must have a well wound faradic coil, capable of backing up sufficient spark gap to excite a small Geissler tube. With such a coil the examination is accomplished without any discomfort or pain to the patient.

In a fair percentage of obscure nervous cases, where deranged menstrual function, backache, spinal tenderness, etc., with a long list of concomitant symptoms this neuro-electric test may clear up the doubt as to whether a given case has an ailment in the pelvic, abdominal or other portion of the body producing the reflex irritation upon the nervous system.

A few illustrative cases will tend to emphasize the growing field in electro-gynaecology, which has been in recent years placed on a secure footing by improved technique and available practical electrical apparatus.

Mrs. D., age 35 years; married four years. She has all her menstrual life suffered from dysmenorrhoea and scanty menstruation with the usual concomitant symptoms of backache, tender spots through lower dorsal spine soreness and tenderness in right ovarian region, etc. Examination reveals elongated cervix antifixion and atresia. Careful dilatation with copper olive pointed electrode attached to the negative pole of the battery, positive pole attached to a large abdominal pad, with a current strength of 10ma, followed by intra-vaginal, sinusoidal current for ten minutes, treatment repeated every third day for two months entirely relieved the trouble. She became pregnant a few months after, followed in a few years by a second successful pregnancy. At the present time she still remains well, although seventeen years has passed since her ailment was corrected.

Miss H., age 26 years. Menorrhagia lasting ten days and returning every three weeks, patient anaemic, weak and languid. On examination, find a relaxed and congested uterus, three and one-half inches in depth, endo-metritis and leucorrhoea. Treatment was commenced with copper electrode intra-uterine, with a current strength of from 15 to 25 milliamperes, from the positive pole of the battery negative pole attached to

a large abdominal pad, each treatment lasting from eight to ten minutes, treatments repeated every third to fourth days.

Her first menstruation following was less profuse, the second event passed to twenty-eight days and the flow lasted only six days instead of twelve. After three months, treatment was discontinued, as menstruation had become normal and the leucorrhoea had almost ceased. A slight relapse six months later caused her to return for further observation, four or five treatments were again applied and she has since remained well.

Mrs. B., age 38 years. Mother of one child of twelve years. Patient of neurotic temperament. She menstruated first at age of 13, normal and regular. After the birth of her child she suffered from uterine displacement which gave her slight discomfort until a flexion occurred at her menstrual periods, at which time the fundus of the uterus would frequently become wedged in the cul-de-sac causing severe menstrual colic and hysterical condition. Examination revealed moderate endometritis, retro-flexion, ovaries sore and tender, uterus not much enlarged. Treatment was commenced negative pole intra-uterine electrode, elevating and straightening at the same time, the direct current was followed by mild sinusoidal intra-vaginal, ten minutes' duration, also at intervals general static electrization. A wool tampon was used to support the uterus between the semi-weekly treatments. This case gradually resumed normal health and with the correction of her displacement her menstrual periods came and passed without pain or dread of the succeeding ones. She passed through the climacteric at forty-seven, requiring some attention remedially, also cervical dilatation for excessive vaso-motor disturbances. No return of the retroflexion developed.

Mrs. M., age 30 years. Mother of two children, suffers from chronic metritis, tender right ovary with pain extending down the thigh, menstruation profuse, patient pale and weak. Treatment intra-vaginal mercuric cataphoresis—a copper ball electrode amalgamated with mercury and covered with moist cotton, negative pole attached to large abdominal pad. After several vaginal treatments, intra-uterine application through the positive pole of the battery with a current strength of 20-25 ma. ten minutes. Static electrization materially improved the general tone of this case, who made a good recovery and remains well—four years.

Mrs. B., age 50. Mother of five living children. She was

advised to have the uterus removed, and presented the following symptoms: Rapid loss of flesh, anorexia, much worried about herself, pale even to a cachectic appearance. On examination found an endo-cervical inflammation with an anterior erosion of the cervix, with the posterior cervical tissue quite hard.

Treatment.—Direct current positive pole copper electrode intra-cervical 15 ma., negative large abdominal pad. After six semi-weekly treatments, sinusoidal current vaginal electrode, was given for two months with an entire clearing up of the condition, patient gaining her normal weight with a restoration of confidence as her health improved. One year having elapsed and no return of her ailment.

Within my own experience, electricity has so largely fulfilled the needs in my gynaecological cases, which cover the field of non-operative treatment, that we feel justified in dividing our cases into two general classes: "cases which require surgical repair, and those who will be benefited or cured by the properly selected and applied electrical modality." It is not within the conception of the writer, however, nor the power of electro-gynaecology to displace or question the splendid and necessary work which modern surgical methods have accomplished, believing any careful student of electro-therapy will recognize the field of importance, as well as its limitations.

Time will not permit me to make more than passing comment on fibroid tumors. Apostoli's electro-chemic method has been abused, ridiculed and misunderstood. I believe largely because imitators lacked initiative and technique. Massey and other electrical investigators have in a measure modified the original methods and we now have fairly precise technical processes, which, if followed, will produce good symptomatic cures with reduction in size of the tumor in many cases—this by the intra-vaginal and intra-uterine methods.

Vaginal puncture in those cases where the tumor is largely in the posterior uterine wall is always to be considered.

In this resume it is understood that the interstitial tumor is the type commanding attention.

Sub-peritoneal fibroids should be surgically removed and are not to be electrically classed with the interstitial.

In closing a few general comments upon the electro-chemic effect of electricity must be always before the operator to obtain a therapeutic accuracy and achieve the results desired.



The positive pole is a vaso-motor constrictor, lessening congestion and checking hemorrhage, the tissues are hardened by acids generated and oxygen gas is liberated. The negative current is a vaso-motor dilator, is infiltrating, improves nutrition by dilatating circulatory channels, the tissues become disintegrated by alkalies formed, and hydrogen gas is liberated. In applying substances by phoresis the metals, hydrogen and the alkalis are electro-positive, oxygen, chlorine and the acids are electro-negative; thus to diffuse iodine through the tissues by a solution of potassium iodide, it is applied from the negative pole, iodine being electro-negative.

The same careful aseptic precautions must be observed in electro-gynaecology as in any other surgical procedure, for although at the positive pole germination is inhibited or destroyed in currents of twenty-five milliamperes or more, the negative seems not to influence bacterial germination.

Much benefit will be derived by patients after receiving the active electric treatment if induced, sinusoidal or static currents are administered for their general and constitutional effects, selected as the needs of the case would seem to require.

In conclusion, I would suggest patient care in the details of electro-therapeutics, for correct application, as to quality and dosage, is as necessary as skillful surgical technique is to operative processes.

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## DISCUSSION.

DR. ANNA D. VARNER: Many physicians condemn the use of electricity because they have never made a study of it and know very little about it. I find that if you select the patient with care and study the type of current that he needs, the results are good. There are three conditions in which I use electricity in gynecological treatment: First, the positive pole to dissolve and soften adhesions and follow that by the sinusoidal current to relieve the pain and distress that some women suffer from for a long time after operations. Second, in cases of dysmenorrhoea, where there is a very small cervix, but where the cervix closes as the result of nervous spasm, I use a copper electrode attached to the negative pole of the machine and introduce it into the cavity of the uterus. I follow this by the use of the sinusoidal current; treatment should be given two or three times preceding the menstrual period and continued for several months. Third, in cases of sterility when the cervix is so small that conception cannot take place, also in membranous dysmenorrhoea. I have had a number of cases of membranous dysmenorrhoea and have only failed to cure in one case.

DR. HEIMBACH: I think that it is true that there are cases, especially where we apply the stimulating currents,—sinusoidal, static, etc.—where we fail to get good results. In the use of galvanism, we have an electro-chemical process and the results are pretty positive in the disintegration of the tissue of the cervix for inflammatory conditions. If you use the copper electrode covered with a small amount of cotton, dipped in a weak solution of sulphate of zinc, the results will always be very positive. I want to verify Dr. Varner's statement about sterility: electricity is capable of doing a great deal of good in such cases.

DR. LANE: Dr. William J. Mayo has said that electricity is the greatest fake of medical history; but I think he does not mean exactly what he says. He evidently means as applied by the physician promiscuously, without a thorough understanding of its use. For years I have been interested in the use of galvanism for dysmenorrhoea. With the steel dilators we get very prompt results which last about a year; but the majority, sooner or later have trouble again. There is no doubt but the galvanic current will dilate the cervix, but the point is—how long will this condition last?

DR. WHITE: My experience has been that with sufficient current the dilation will be permanent. An important point is

to use the sinusoidal current in toning up the organ after each treatment.

DR. LANE: How long have your cases stayed well?

DR. WHITE: I should say that about 75 per cent. are permanently cured in my experience.

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## THE EARLY RECOGNITION OF EXTRA-UTERINE PREGNANCY.

BY

R. C. CASSELBERRY, M. D., CHESTER.

THIS is a condition which we should be on the lookout for more often than we are. As a rule it is one of emergency and being such demands prompt and proper attention. If all cases of amenorrhea, metorrhagia or other abnormalities and irregularities of the menstrual function received the same careful examination that a pain in the right iliac fossa, or a pain in the cardiac region does there would be less suffering, and in some instances a lessened mortality rate. False modesty and prudishness of course must shoulder their part of the burden. A physician must have the full confidence of the patient in order to render the best service, and, where he feels it is not given he should refuse to treat or prescribe for such patients.

Any physician or surgeon who is too lazy, indifferent or incompetent to give to his cases an intelligent and scientific examination and get to the bottom of the trouble should not be fortunate enough to have cases for examination.

Perhaps one reason why there are so many mistakes made is that the average physician is underpaid and feels that he is giving as much as he gets. This, of course, is the wrong attitude for a physician to assume, but, nevertheless it is true. He may be tired or wants to get through quickly and consequently may miss some cardinal symptom which might have saved—no one knows how much.

The diagnosis of extra uterine pregnancy is far from easy and some of the best gynecologists hold that it is almost impossible in the early stages.

There are cases that have ruptured fifteen days after the cessation of the menstrual flow, even before the patient had any idea that there was something wrong with her. When the con-



dition has covered the period of six weeks it is comparatively easy to make correct diagnosis. Up to that time it would be next to impossible to come to any positive conclusion that we were dealing with a case of extra-uterine pregnancy.

Frequently the difficulty is that the patient does not think that there is sufficiently wrong with her to consult a physician. When she finally does make up her mind to see one, she either treats it lightly or misleads him, so, that if he is not wide awake and alert she goes home convinced that she is all right.

The next thing that happens is the sharp pain and collapse which follows a ruptured tube. Life or death now depends upon the character of the hemorrhage and the availability of a surgeon and hospital.

Ectopic pregnancy prior to rupture has been recognized and successfully treated surgically; the great majority, however, rupture before recognized.

When a patient in apparently good health with a history of pelvic disorder, and perhaps sterility, consults you, giving a menstrual history of amenorrhea varying from a few days to weeks, or else a protracted menstruation, or an intermittent flow, associated with sore breasts, pains of a colicky nature in the pelvis, morning nausea, we should think of the possibility of an ectopic gestation.

A pelvic examination showing a slightly enlarged uterus, without the compressible zone between the hard cervix and the body of the uterus, and a sensitive tubal tumor lying laterally or behind the uterus, with the contiguous ovary separate and the opposite tube and ovary healthy, we would be justified in making a tentative diagnosis of extra-uterine pregnancy.

I recall a case under my care about five years ago who had a history of menstruating for a month prior to my attendance. I attended her for a month without results or without being able to come to a positive diagnosis of what was the cause of the metorrhagia. There was tenderness over the right tube with severe pain at times. There would be flooding for a day or two and then a cessation for about the same length of time. The uterus was enlarged and soft. A little later I could detect a small mass in the right tube. I advised operation feeling that in the right tube we would find the seat of her trouble. There was objection to this and we called in a prominent surgeon. He advised waiting, fearing that the uterus was pregnant.

The flow continued as before for about five or six weeks

longer when it gradually ceased. The tumor at this time was the size of a small egg, but, from this time on it diminished so that in about three months it had entirely disappeared. There is no doubt but what this was a tubal pregnancy which formed a tubal mole and later became absorbed. Two years later she became pregnant and has now a healthy child a year old. I believed if she had consented to an operation when I advised it she would have saved herself months of suffering and distress.

To illustrate the difficulty in recognizing an early extra-uterine pregnancy I would like to cite a case I operated in July of the present summer.

This woman had paid several visits to a physician's office, covering a period of two or three weeks. She complained of pain, severe at times, and just a heaviness at other times, over the lower part of the abdomen. She was at all times tender to palpation. The condition not improving, and with an increased tendency to sharper pain, she was sent to the hospital. She ran a temperature chart from 100 to 102, a pulse ranging from 90 to 120. The pain at this time seemed to be more of a dull character rather than of the cutting or lancinating type. The patient was examined by two surgeons who believed there was a right pyo-salphinx with a mass in the left pelvis. I operated the case without having seen it previous to being anasthetized. On opening the abdomen found the pelvis filled with blood, which was mostly in the form of large dark clots. It was walled off from the upper abdominal cavity by adhesions formed for the most part by the omentum. After cleaning out the blood we found a ruptured left tube with placenta attached. The tube was removed as well as the ovary. An examination of the right side revealed a large hæmosalphinx filling the lower right pelvis. After considerable difficulty on account of adhesions this was removed. It was enormous and filled with blood. At first it was thought we had a double tubal pregnancy, but were unable to verify this.

This case lacked the usual symptoms of ruptured tube, namely, sharp, lancinating pain, collapse, pallor, cold and clamminess, and with possible unconsciousness if the hemorrhage be severe. The enlarged right tube felt by the vaginal examination, and the rise in temperature, which was probably due to the absorption of extravasated blood, gave the impression that pus was present. I believe that to have given a true diagnosis of

her condition before the operation would have been next to impossible.

During the past five years we have had seven extra-uterine pregnancies at the Crozer Hospital, but, have not been able to get them before rupture. However, we were fortunate enough to save them all.

The recognition of this condition before rupture takes place would do away with a great deal of the danger, for then the operation could be done with the least possible shock to the patient.

A possible diagnosis may be made after fetal death, because there is usually a discharge of decidual tissue and uterine hemorrhage.

It has been the general belief that the discharge of a decidual membrane or the presence of a decidual tissue in an empty uterus, where a tumor or mass can be detected on one side of it, is a positive diagnostic sign of extra-uterine pregnancy. On the other hand, the absence of it is not negative.

These discharges following a history of amenorrhea associated suddenly with fainting, pallor and collapse, the diagnosis of ruptured tube with hemorrhage into the peritoneal cavity becomes practically certain. The hemorrhage may be slow and the patient have alternate periods of collapse and recovery. If the condition is promptly recognized and suitable cases operated many lives would be saved that otherwise would be lost. A systematic examination and intelligent study of all our cases is the only safe and sane way of saving ourselves and others.

#### DISCUSSION.

DR. MADDUX: Those of us who are called upon to operate cases of extra-uterine pregnancy will recognize that there are no special difficulties attending the operation, but that the matter hangs upon the diagnosis of the condition in its earliest stage. I wish to emphasize the importance of a careful vaginal examination in all suspected cases.

DR. ROBERTS: While we are discussing this subject I would like to cite a case of unusual character: A young woman twenty-eight years of age had been married several years and had had no children. She had menstruated regularly until the last period which was overdue however. She had been apparently well until she was suddenly taken with pain in the pelvic region. She became very weak and died within eight hours. A



post-mortem examination showed a considerable amount of free blood in the abdominal cavity and a ruptured left ovary. The tube was absolutely intact.

DR. DIETZ: In connection with ectopic pregnancy, I always suspect its presence when a woman who has been regular with menstruation becomes irregular with occasional spells of bleeding and pain in the pelvic region.

DR. GRAMM: The subject of extra-uterine pregnancy is one in which I am intensely interested. The diagnosis of the subject is one that ought to appeal not only to the operator but to the general practitioner as well. The first point I would like to emphasize is, that the physician should always be on the lookout for this condition. The second point I would like to emphasize is the fact that ectopic gestation usually occurs in a woman who has previously been sterile for a number of years. There is usually some menstrual irregularity. It may be only for a few days, but more probably for four, six or twelve weeks. In many instances there will be decidual tissue in the discharge. A vaginal examination will show the foetal mass near the uterus, the uterus itself being only slightly enlarged; later, there will come a sudden pain accompanied by all signs of abdominal hemorrhage such as collapse, pallor, etc. For many years it was a debated question as to whether ovarian pregnancy could take place. It is now recognized as possible for the ovum to be impregnated in the ovary.

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## THE TECHNIQUE OF ABDOMINAL HYSTERECTOMY.

BY

N. F. LANE, M. D., PHILADELPHIA.

Clinical Professor of Gynecology, Hahnemann Medical College; Gynecologist Hahnemann Hospital; Surgeon Woman's Southern Homoeopathic Hospital.

THE following technique for abdominal hysterectomy contains nothing particularly original, but it is one that I have evolved from observing other operators and taking that which I considered the best from all, a composite picture if you please. Others may use the same technique, most operators comply with the essentials, and my object in writing upon this subject is to still further develop, if possible, the effectiveness of this operation, so the patient may be left in the best possible condition both anatomically and symptomatically. In a multitude of opinions there is usually some wisdom.

Methods described must, from the nature of things, be taken

to apply to uncomplicated cases, and by complicated cases I do not mean the size of the tumor, as that need not necessarily alter in any particular the technique of the operation; but I do refer to adhesions, inflammatory conditions of the adnexa or irregularities of the growth which may render the ordinary procedure impracticable.

In passing I may say that a surgeon's name appearing in parenthesis following any particular part of the technique does not necessarily mean that he was the originator of the method, but that he was the source of my information, gathered usually by observation.

The profession is no doubt indebted to Dr. B. F. Baer for the modern hysterectomy. Previous to his description of the operation in 1892 the usual method was to deliver the tumor from the abdomen, apply an ecraseur to the supra-vaginal portion of the cervix, pass long pins through the cervix to keep it from retracting into the abdomen, amputate the tumor and close the abdomen with the cervical stump protruding from the lower angle of the wound. The ecrasure was tightened as often as necessary to keep up constant constriction and in the course of a few days the stump outside the constricting wire was amputated, leaving a granulating wound. By this time the stump was extra-peritoneal by virtue of the adhesions which formed between the stump and the abdominal incision. The stump gradually retracted into the abdomen and the patient was left with the cervix attached to the abdominal wall much after the fashion of a modern abdominal fixation of the uterus except that the fundus was absent. This was a good operation and worked out well, but was just as unsurgical as any fixation operation. There was some danger of the stump retracting into the abdomen prematurely and setting up a peritonitis or an infection of the cellular tissues. While this may be said to be a remote danger, I saw one death from this cause. Personally, I never performed this operation although I assisted at many. The new operation was introduced before I began to do major work.

After opening the abdomen and clearing the field of operation of intestines possibly the best thing to do first (if the size or shape of the tumor does not interfere) is to incise the peritoneum on the anterior surface of the uterus and separate the bladder from the uterus, thus exposing the uterine arteries which are ligated or clamped (Deaver). The broad liga-

ments are next clamped either inside or outside the ovaries as the case may be and the broad ligaments are divided down to the transverse incision previously made. By ligating the uterine arteries first all bleeding is usually controlled without placing two clamps upon the broad ligament. The reverse is often easier, that is, to ligate or clamp from above downward. The cervix is now amputated leaving a V-shaped depression in the cervix and the cervical canal is cauterized with carbolic acid (Deaver), or by the electric cautery (Clark). All bleeding should now be controlled, making the field dry. The broad ligament is tied with chromic cat-gut and the same ligature may be used to attach the broad ligament stump to the depression in the cervical stump by threading one end on a needle and passing it from the V-shaped depression, forward through the anterior lip of the cervix and the other end of the ligature in the same manner, backward through the posterior lip of the cervix and while drawing the stump of the broad ligament into the depression of the cervix with forceps, the two ends of the ligature are tied over it (Deaver). This makes a very neat and pretty operation, but personally, I dislike to make traction on a ligature that is controlling a large blood vessel like the ovarian artery. I usually use a separate ligature to bury the broad ligament stump in the cervix, getting practically the same result.

After treating both sides in this manner we have nearly all raw surfaces covered and all that it is necessary to do to complete the operation and cover all surfaces is to draw the bladder flap of peritoneum over the stump and stitch it to the posterior part of the cervix thus leaving absolutely no surface to form adhesions. Attaching the broad ligaments to the cervix effectually prevents any prolapse of the cervix or vaginal walls.

If a complete hysterectomy is to be done we may proceed as follows: After the uterine and ovarian vessels are ligated as before described and the broad ligaments cut, the bladder is still further separated from the cervix and vagina, the cellular tissue in the broad ligaments separated from the uterus (care being taken to lift off the ureters) and the vagina amputated at the desired point. Access to the vagina may be easily effected by opening the cul-de-sac of Douglas upon a piece of gauze which is placed in the posterior cul-de-sac of the vagina when this organ is sterilized previous to the operation. The end of the gauze is left protruding from the vagina and is re-



moved by a nurse as soon as the vagina is entered (Montgomery).

The operation is completed by attaching the broad ligament stumps to the vagina and covering the whole with the bladder flap as before described. Some operators do not entirely close the vagina, leaving a small drain into the vagina. The abdomen is closed in the usual manner.

In certain rare instances operators have found it expedient to bisect the uterus and remove each half separately, from below upward (Kelly). I have had no experience with this method as I dislike to open any tumor in the abdomen unless it is necessary. We can never be sure that its contents are sterile.

Numerous methods have been described suitable to certain complications, and while it is well to be familiar with all procedures, still as a matter of fact, we must usually devise a method to suit the case after the abdomen has been opened and the exact nature of the complications revealed. After all it is the facility with which a surgeon handles complications that determines his ability as an operator.

I have left for the last the consideration of the radical complete hysterectomy, by which I mean not only a removal of the uterus, but also the parametrium and sometimes the pelvic lymph glands. This operation is performed in malignant cases only and while I did not intend to go into the pathology associated with the operation of hysterectomy, still the technique can hardly be studied without some slight reference to it.

It has not been my custom in the past to do the complete operation as I considered that if I could not get all the tissue involved by the ordinary operation I was not likely to make any better progress toward a cure by doing the radical operation, and as the mortality of the complete operation is so much higher I did not feel justified in submitting the patient to the additional immediate risk to her life. This position is probably correct in the majority of cases, but there must be cases occasionally where the removal of the parametrial tissue will remove the point of greatest extension of the growth and thus cure the patient permanently.

In conformity with the above I have lately somewhat changed my idea in regard to these operations and now feel that at least a wide dissection of the adjacent tissues is justifiable. It is the operative mortality that makes us hesitate, but why should we consider the operative mortality so carefully when the non-

interference mortality is one hundred per cent. and the ordinary operation is not much better when the cervix is involved primarily, for the reason that we get the cases so late. No man likes to increase his operative mortality, but is it not our duty to recommend this complete operation to the patient and her friends, and to be willing to assume our part of the responsibility of the patient so wishes to add to the prospect of a cure?

I have come to the conclusion that any extensive operation for malignancy is contra-indicated in excessively fat individuals. The difficulties are enough in ordinary individuals and when six inches of fat is deposited in the abdominal wall and a corresponding amount in the omentum and other viscera, the difficulties are such that the operation had better not be undertaken.

The technique of the complete operation is much the same as in the ordinary operation except that a wide dissection is made by lifting back the ureters and freeing the bladder from the vagina, thus giving access to the tissue in and around the base of the broad ligaments. If the pelvic glands are removed the peritoneum must be split up along the great vessels to the desired or necessary height.

In relation to the pelvic glands I think we can truly say that if the enlarged gland is carcinomatous (which they often are not) the case is practically hopeless even if all accessible glands are removed so that I like the position assumed by Dr. Peterson, of Ann Arbor, in relation to this subject as set forth in an article appearing in *Surgery Gynecology and Obstetrics* of August, 1912. This article and others on the same subject in the same issue will well repay study if one is interested in this subject.

I quote a paragraph from this paper:

"It can hardly be claimed by the most enthusiastic advocate of a complete glandular dissection of the pelvis that it is as possible in this operation to make as complete lymphatic removal as where the glands are more favorably located, for example, in the axilla in connection with cancer of the breast. In other words there is greater chance of leaving behind cancerous glands or portion of glands when the dissection is made in the pelvis. Second. Such dissection undoubtedly greatly prolongs the operation and adds to the danger of shock. Third. The best statistics at the present time show that probably in the class of cases suitable for the radical operation not more than

one third have any glandular involvement. Fourth. The results of Wertheim and others who make only a partial glandular dissection show that, after all, the good results of the radical operation come from a wide dissection of the parametrial tissue, not from removal of glands.

"If the above be true, it certainly follows that the removal of the pelvic lymphatics should be left for the last step of the operation, only to be performed if the strength of the patient permits."

#### DISCUSSION.

DR. GRAMM: The operation of abdominal hysterectomy is one of particular interest to us because of the fact that the development of the several stages of the technique is an accomplishment of distinctly American surgeons.

The first hysterectomy was done as early as 1843 by a man named Clay and the patient died; there was another in England in 1854 and one in France in 1858, both cases proving fatal. Washington Dudley, in America, performed an operation successfully in 1844 and in 1864 Keberly introduced the method of suturing the stump of the uterus and this method was used for a number of years.

The retro-peritoneal treatment of the stump is due to Emmet, Eastman, Dudley and Guffe. This has been a tremendous advance in the treatment of these cases. I am very glad to have heard this paper which is up-to-date and portrays for us the accepted technique of the operation as it is performed to-day.

DR. PATERSON: Dr. Lane speaks of clamps and ligatures: most of the Western surgeons use clamps and I was somewhat impressed with their value until I lost a patient from post-operative hemorrhage which was thought to be due to placing the clamps on the vessels instead of ligatures.

In regard to the operation for malignant growths of the uterus—I understood Dr. Gramm to discourage the dissection of the lymphatic structures. In my opinion we should search for the pelvic lymphatics and remove them just as we do in operating for cancer of the breast.

DR. LANE: I always use gauze packing in operating, but always wet it in salt solution first. It is the use of dry gauze that causes subsequent adhesions.

The question of the removal of the glands is one concerning which a variety of opinions exist. The proper method is to



first remove the uterus and as much surrounding tissue as possible and if the patient's condition is good remove the glands. If the patient's condition is not good, do not try to remove the glands as it prolongs the operation to an unwarranted extent.

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## BUREAU OF PEDOLOGY

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### THERAPEUTICS OF GASTRO-ENTERIC DISEASES.

BY

ANNA D. VARNER, M. D., WILKINSBURG.

At the request of the chairman of this bureau, I have prepared a paper upon this subject. To cover the therapeutics of all gastro-enteric diseases thoroughly would encroach upon your time and tax your patience beyond endurance; so if you please, we shall conduct an imaginary hospital clinic. Granting that all the cases have been diagnosed according to the most approved modern methods, we shall make it our business only to apply the treatment best adapted to bring about a cure.

The first group of patients are suffering from acute gastric indigestion or gastritis. In each case a tepid sponge bath is ordered daily to allay fever and restlessness, unless contra-indicated, also gentle massage of body with olive oil. Our first care is to empty the stomach, to accomplish which we order a large amount of warm water given from the nursing bottle followed by a high enema. In obstinate cases we prefer a thorough washing of the stomach. All food is withheld from twelve to twenty-four hours or longer, as the case may require, then one-half ounce of whey, barley or albumin water is given every hour for the first day. If everything goes well, a little raw beef juice or broth is added, followed in three or four days with peptonized milk.

When the vomiting is continued and persistent, rectal feeding may be used for a short period and nothing given by the mouth excepting a little cracked ice. Beef peptones and peptonized milk are used every four to six hours.

Our first little patient has a temperature of 101 degrees, his

skin is dry, his lips cracked, his tongue coated white through the middle, dry and red around the edges. All his secretions seem dried up; he is very thirsty and drinks large quantities of water, he vomits food as soon as it is taken. His stomach is sensitive to the touch, he is peevish and fussy but is afraid to move. When he sits up he gets pale and nauseated and seems faint and dizzy. We prescribe bryonia because it covers all these symptoms and as its physiological action is to arrest and dry up secretions of the mucous membranes of the digestive tract, it corresponds closely to the pathological condition of the child.

The next patient lies in a semi-stupor, his face is very red, his temperature is high, his pupils dilated, his muscles jerk and twitch. The nurse tells us he has frequent spasmodic attacks of hiccoughs and frequent empty retching. He cries out in pain and we know from his actions that he has pains in his stomach, so we leave some belladonna and pass on to the next.

Our troubles begin. On our approach, this little girl screams and is so cross and cranky we cannot examine her thoroughly. We get a peep at her tongue which is coated white all over like a coat of whitewash, very different from the partial coating of bryonia. She has no fever and no active inflammation of stomach, rather her functions seem depressed and the mucous membranes loaded with mucous. Her digestion is slow with fermentative flatulence. She is nauseated and has attacks of vomiting; vomiting milk as soon as taken and which she refuses to take again. Constipation and diarrhœa alternate. The stools are the consistency of pap, aggravated by acid fruits which the child craves. Fights if the nurse tries to bathe her face with cold water. Now the chamomilla patient is cross, but likes to be carried—whereas this child refuses to be touched—therefore we select antimonium crud.

We find the next patient also craving acids with aversion to milk. She clamors for cold water, but there is excessive sensibility of the stomach and even the smallest mouthful of food causes pain and uneasiness. She is suffering with great nausea, with repeated attacks of vomiting accompanied with retching and straining. She is feverish—the condition of the stomach is decidedly inflammatory; we consider two remedies which will produce such a condition—antimonium tart and ipecac, but we remember that ipecac has a constant and unavailing desire to vomit, or no relief after vomiting with a desire

immediately to vomit again and a facial expression of nausea and disgust for food, but this child is relieved for quite a time after vomiting; moreover, she is drowsy and her pupils contracted, hence we decide to give antimonium tart.

Case No. 5 is a boy two years old. We notice that his gums are bluish red and painful, bleed easily, his teeth are peg-shaped and already show signs of decay, all characteristics of congenital syphilis. He has foul breath, apthons ulcerations, belches frequently, has a sour regurgitation and sometimes after a meal vomits undigested food. He likes meat, especially smoked bacon, his symptoms are all worse after cold food. Warm food ameliorates. His stools have a cadaverous odor. We feel certain that this child has superficial ulceration of the stomach and so we think of kreosote whose action is to produce inflammation and ulceration of the stomach and whose symptoms correspond exactly with those manifested in this case.

For the next pale, fat, flabby baby we can easily prescribe. The sweaty head, open fontanelles, toothless gums, sour vomiting, sore tongue, swollen stomach (like an inverted saucer), copious sour smelling, chalky stools all point to *calcareo carb.*

In the next ward the children are afflicted with simple diarrhoea and ileo-colitis. There should be no crowding as the children need plenty of fresh air. The diet should be as restricted and as carefully regulated as in cases of gastritis. The colon should be irrigated daily with normal salt solutions.

Case No. 1 presents the following symptoms: Dry lips, nausea, gagging, vomiting, no appetite, no thirst, abdomen distended with gas, much rumbling in the abdomen and colicky pains. The stools are yellow, or yellowish green, urgent and the evacuations are made in one sudden gush, like a shot, followed by prostration and aggravated immediately after eating and drinking, especially hot milk. The remedy of course is *croton tig.*

Case No. 2. This sallow looking child is drowsy and lies with eyes half closed moaning and rolling its head. It has no appetite but thirsts for large quantities of cold water. Here too we have profuse gushing, urgent stools, but they contain undigested particles and soak the napkin through with a dirty looking, greenish water. They are very offensive, worse in the morning, better lying down and keeping still, and are accom-



panied with marked tenesmus and prolapsus ani. Podophyllum will help this child.

Case No. 3 is an emaciated child with flabby skin, peevish and cannot bear to be bathed; a dirty, greasy looking child with a bad odor about the body, a ravenously hungry child, who cries for food between meals. His lips are red, his hands are hot and sweaty. He has an itching eruption on face and body, he will not stay covered. His stools are urgent, involuntary, fetid, white, mucous, painless, excoriating. The anus is fiery red and very sore. Who would not give this baby sulphur?

Case No. 4 is another dried-up looking child—a regular mummy. He has griping pains in the bowels and every little while jumps and screams as though a pain had passed through him like an electric shock. The abdomen and stomach are distended with gas which presses upward, but is difficult to eruct. The belching is loud and violent when it does occur. The stools are frequent, fetid, green, slimy, shreddy, membranous, containing blood and inflammation of the bowels. Motion, exercise or any excitement aggravates his diarrhœa. When he drinks water it seems to pass through him at once. He has an irresistible desire for sweets but is always worse after eating sugar. His prescription is undoubtedly argentum nit.

We give the next child colocynth because she is in great pain. She twists and turns and bends double and is only relieved when the nurse presses hard against her abdomen. Her pain is aggravated from eating or drinking the smallest quantity. Her stools are slimy, frothy, greenish yellow and even bloody at times. She is better from moving about the bed and from warm applications.

Now chamomilla has severe colicky pains and tosses about but does not double up. Veratrum has severe pains and doubles up with it, but veratrum has cold sweat and pallor Dioscorea has severe colic but the patient stretches out instead of doubling up. All these little points help us to differentiate between several very similar remedies.

No. 6 is another puny, sickly, marasmic looking child with lax fiber and defective nutrition. This is a sour baby—stools, sweat, breath, body, ejecta, all smell sour. The child is thirsty and we find apthous ulcers in her mouth. The stools are green, like scum on a frog pond, and contain jelly-like lumps. She has colic and screams before, during and after stools. She likes

meat, but has an aversion to milk and will not take it; also has aversion to uncovering. Rheum and magnesia carb are both sour remedies, but the rheum baby cries all night, its hair is sopping wet with perspiration and it lies doubled up in very queer positions, while the stools are brown instead of green—hence our choice is mag. carb.

Case No. 7 is a very sick child, very thirsty for cold water—refuses everything but cold water and cold food, which are vomited as soon as they get warm in the stomach; nevertheless, she is hungry and wants to eat often. Not only vomits food, but bile and blood. The abdomen is hard, distended, sensitive with spasmodic colic. The stools are copious, greyish white, watery, odorless, and pass at short intervals from a wide open anus. There are tearing pains in rectum causing child to scream out and clutch at anus, and these pains are relieved by warm applications. This patient will do well under phosphorus.

Our last patient in this group is a good natured child who is neither thirsty nor hungry and will not be covered. Her tongue is coated whitish yellow and is covered with tenacious mucus. There is an offensive odor from the mouth. She has flatulence, rumbling in abdomen, some colic. Stools are worse at night, are very changeable, no two alike, mucus, bloody, green, white. Pulsatilla is the remedy.

In the next ward we find several cases of cholera infantum. It is very necessary to apply heat to the body and give high hot saline enemas.

The first patient has been taken suddenly ill. There is marked nausea and vomiting, rattling in the throat, hot breath, expression of distress and collapse. Cramps in the bowels with icy coldness of extremities; body also icy cold yet throws off the covers. No bowel movements—hence we give camphor.

The next child is vomiting violently and copiously, a greenish, slimy, acid, foamy mucus. Insatiable thirst for cold water, which is vomited. Cramps in the stomach and legs; frequent copious, watery, greenish stools with flakes and very little substance or color. We see here a rapid sinking of the vital forces, face blue, hippocratic, nose cold and pointed, limbs cold; profuse cold sweat on face and body. Great prostration following stool. If not speedily helped this patient will die. Heat is applied to the body externally, hot salines per rectum every four hours and veratrum alb. in oft-repeated doses until the patient is better.

The third case had two convulsions at the beginning of his attack. Vomiting terrific and spasmodic, relieved by a drink of cold water, dyspnoea is intense, the abdomen is as hard as a stone. Stools are profuse, flocculent whey-like fluid. The patient is collapsed, skin blue, surface of the body cold, muscles of calves and thighs are drawn up in knots. Spasms and cramps predominate, indicating cuprum met. as the remedy.

Case No. 4 is in a very serious condition; gasping for air, face hippocratic, breath cold, legs cold to knees, collapsed. The pulse is rapid, thread-like and the prostration so great that the patient lies quiet, too weak to move. The evacuations from the bowels are liquid, mucous, involuntary, putrid with bleeding from anus and nose. The abdomen and stomach are greatly distended. The prostration here is not the result of sudden shock to the system as in camphor and veratrum, but is the result of continued exhausting alvine discharges. The disease has almost run its course, perhaps nothing can save, but we shall try *carbo. veg.*

The next child lies rigid with hands clinched or fingers spread apart—the muscles twitch, the eyes are sunken, features pinched. The patient is cold and pulseless, retches without much vomiting. His skin is dry, harsh, shriveled, urine suppressed. Stools are profuse, watery, undigested, ejected with great violence or by fits and jerks. Patient is cold yet cannot bear to be covered. *Secale* is the indicated remedy.

We have three cases of dysentery demanding our attention. The first little fellow is in a bad humor. He is irritable and cranky; nothing suits him, his tongue is thickly coated on the base, his mouth is dry, sore and full of ulcers. He has no appetite and no thirst, has some nausea and sour vomiting; the abdomen, which is distended, is very sensitive to the touch. There is frequent urging to stool. The stools are small, thin, brownish, bloody mucus with pain and tenesmus which ceases after the movement. He likes to be warm, does not throw off the covers and seems worse in the morning. The remedy is *nux vomica*.

The next patient also has small, bloody stools with pain and tenesmus which continue without relief after the movement. Violent thirst, calling for water all the time. Nausea and bitter bilious vomiting. Tongue moist, with ulcers around gums. The urine is scanty, hot, bloody, albuminous, and the child cries on voiding it because there is also pain and tenesmus of



the bladder. Profuse sweat on every motion. We prescribe merc. sub. cor.

Our last patient is very restless, feverish, flushed—corners of mouth are sore, ulcerated, with fever blisters. Tongue is dry, cracked, with a red triangular tip; stools are bloody, watery, jelly-like, odorless and the stools, thirst, colic and restlessness are all worse after midnight. *Rhus tox* is the remedy.

You will say that this is old-fashioned symptomatic prescribing. So it is, but every remedy mentioned has a specific physiological action upon the gastro-intestinal tract; moreover, we can show you that there is a definite relation between even the peculiar characteristic symptoms of a drug and its physiological action. Take, for instance, that great remedy, arsenicum, so frequently indicated in any one of the diseases mentioned in this paper. Its sphere of poisonous action is the whole digestive tract from the mouth to anus. It produces a destructive inflammation of the mucous membranes with icherous discharge, apthae of the mouth and ulceration of the stomach. At its worst, it has a tendency to malignant ulceration and gangrene of rectum and anus. It is a drug that poisons to kill. Now you take a patient suffering with intense enteric inflammation and ulceration and you will be able to match up symptom for symptom—all the peculiarities of the patient, with the characteristics of the drug. Why not have obstinate nausea and vomiting of everything taken into the stomach, even water when the mucous membrane is so terribly irritated. Why not have a bloated abdomen and a stomach sensitive to touch and an unquenchable thirst when the mucous membrane of the intestinal tract fairly crackles with inflammation. How can there help but be restlessness, anguish and fear of death in adults when the arsenicum patient stares death in the face? You would certainly expect to find involuntary, cadaverous, watery, bloody, black, dysenteric stools with dreadful straining and burning at anus with intense suffering, violent pains in abdomen, great prostration after stools, pallid skin and cold extremities in one suffering from such destructive gangrenous ulceration of the intestines. You can even understand why such a patient would be restless and worse at night, why eating and drinking aggravates and in such deterioration of the blood why heat is soothing to the patient.

Careful, thorough, symptomatic prescribing always covers the pathological condition.

Last winter I had a little patient aged five, suffering with a complication of pneumonia and gastritis. For a week or more she suffered with pains in her stomach and vomiting after taking food. She could not take acids at all. Very distressing attacks of vertigo came on suddenly every one or two hours. They were so severe that they frightened the child almost into convulsions. Trembling from head to foot, her eyes starting from their sockets in her terror, she would scream that she was falling and that everything in the room, even her mother, was upside down. These attacks came on without any provocation while lying still and left her in an exhausted condition. Now gelsemium and causticum have vertigo with sensation of falling, and in bufo objects seem inverted. I tried one or two of these remedies without any results. With the help of a friend, we searched Kent's Repertory and Clark's Materia Medica; under guarea we found these symptoms: Objects appear upside down and sensation as though the brain were falling forward, also aggravation from acids, the soreness and tension in the stomach and a dry, tight cough with soreness in chest. I had Boericke and Tafel send me some by special delivery mail. After the first dose she had but one slight attack of vertigo and began to gain in every way. I want you to pay particular attention to the fact that when we found the remedy with the peculiar characteristic symptoms it also proved to be a remedy with a decided action upon both the stomach and respiratory organs. In what way would the physiological pathological routine prescriber have reached this case? It is not my purpose to belittle any modern method, biological, pathological or surgical, that can be of benefit in diagnosing and treating our patients. The physician is a back number who does not familiarize himself with all these subjects, but little do sick people and distressed parents hovering over their afflicted children care how much you and I know about bacteriology or pathology. In all justice to our school of medicine, our patients and ourselves we need to learn more in college and out of it of our materia medica. We are having to fight for our rights these days. Our enemies would annihilate us and legislate us out of business. Without our materia medica what excuse have we to exist?

It is a mistake for us to neglect our own remedies and turn to drugs which the old school physicians are daily discarding as useless; and what do we find in their journals? Why, this physician has discovered that ipecac in very small doses will stop

vomiting; another one has found out that strychnine in large doses produces convulsions—in small doses stops them. Only this month in one of their periodicals a writer claims that the use of the vaccine treatment means that they are subscribing to the doctrine "*Similia similibus curantur*," that the difference in the application of this principle by the two schools is one of substance only. They use germs and serums and we use chemical agents and he closes his article by an appeal to scientists of their school to substitute chemicals for bacteria which he is sure they will find as interesting as their former work with germs and their products. Well, well, they are getting a little warmer all the while.

Now, "He who runs may read"—and 'twould be a pity if we of this day and generation through neglect of our *materia medica* should sell our "birthright for a mess of pottage" and twenty-five years from now witness the spectacle of some base usurper wearing the wreath of laurel that should adorn the brow of our illustrious Hahnemann.

#### DISCUSSION.

DR. W. A. SEIBERT.—There is a great deal in this paper that appeals to the homœopathic physician, especially the portion dealing with the differentiation of the homœopathic remedies. Another portion of the paper that impresses me favorably is the appeal for more symptomatic prescribing. We are coming back to the old fashioned method of prescribing.

DR. C. S. RAUE.—One of the best methods of teaching *Materia Medica* that I know of is to draw a picture of the drug which will suggest a patient just as one presents himself in daily practice. For example, we may note the mental state whether the patient is restless or drowsy or comatose, and from this we can draw a conclusion as to whether the patient is profoundly toxic or acutely ill. Symptom after symptom then presents itself such as posture, the facial expression indicating pain, cough, etc., and if we try to present the remedy in this way the student will remember it more readily.

DR. T. H. CARMALT.—I have nothing to add except my commendation to this excellent paper. Even the members of the old school are now advocating differentiation of remedies by this method. And if we can always present our cases showing this fact—that we prescribe for the individual peculiarities of the patient—we shall aid the art of homœopathic prescribing.

DR. HEIMBACH.—In connection with gastro-enteritis, I had a case with a peculiar symptom, namely, vomiting, worse upon taking liquids, especially water. Bismuth cured this patient promptly.



## EDITORIAL

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### THE FRIEDMANN TREATMENT OF TUBERCULOSIS.

FOR the past few weeks the newspapers have contained frequent articles in regard to the treatment of tuberculosis by a method devised by Frederick Franz Friedmann, which he claims, will promptly and permanently cure this disease.

On the 26th of January Dr. Friedmann arrived in New York and since that time has administered his preparation to a number of patients who are now under observation. He made the following statement in regard to his vaccine: "It is an innocuous, non-virulent living tubercle bacillus derived from a turtle. The original turtle from which the germs were taken was found about nine years ago in Italy, suffering from spontaneous tuberculosis. I discovered shortly afterward that the turtle bacillus is never virulent."

It is as yet impossible to express any intelligent opinion as to the value of Friedmann's treatment. He has made sweeping statements in regard to the efficacy of the vaccine in controlling tuberculous processes, but, in America, at least, he has not as yet confirmed these statements by clinical results.

Some time ago Friedmann presented the matter before the Berlin Medical Society and the facts brought out in the discussion were not altogether favorable to the new treatment. While he stated that the bacillus he employs is derived from the turtle, he has made no exact statement as to its characteristics or as to the methods employed by him in preparing his vaccine.

Erich Muller stated that he had seen some children who had been treated by Friedmann and the injections seemed to be harmless. He believed also that they had some prophylactic power.

Wolff-Eisner said that he considered the evidence of Friedmann as to the harmlessness of the vaccine and its therapeutic value as being inadequate. He believed that some of the cases recorded as cured were not really cases of active tuberculosis.

Bier reported that he had seen a number of Friedmann's

cases and had received the impression that they had been benefited by the treatment, but that he did not consider the evidence conclusive.

Schwenk disagreed entirely with Friedmann's statement. He stated that he had examined one of the cases reported by Friedmann as cured and had found that, far from being cured, she was not even improved. She had been under Friedmann's care since 1911 and had received six injections.

Many of the men who took part in the discussion of Friedmann's before the Berlin Medical Society are men of international reputation and thoroughly familiar with every aspect of tuberculosis. The consensus of their opinion seems to have been that so far Friedmann has proven nothing definite.

That he should be given ample opportunity to demonstrate the truthfulness of his claims, every one will agree, but so far we have been able to learn of nothing of the treatment that justifies hysterical enthusiasm, nor is there any clinical evidence as yet for believing that the much-sought for specific for tuberculosis has at last been found.

G. H. W.

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### MEASLES.

DURING the early months of the year the prevalence of measles in many sections of the country naturally draws the attention of the profession to a consideration of this disease. During the last few years, since it has been found practical to produce the disease artificially in monkeys, a number of important clinical facts have been ascertained.

The virus of the disease is found to be present in the blood serum. This virus is capable of passing through a Berkefeld filter and is destroyed by heat at 55° C. for fifteen minutes. It resists drying for three and a half hours.

The secretions from the mouth and nose are found to be infective for monkeys in all cases where they are collected within twenty-four to forty-eight hours after the appearance of the eruption. These secretions lose their infectivity with the approach of convalescence, and the scales from the skin of a patient suffering with measles do not seem to be infective at all.

When the virus is injected into the monkey, there is a rise of temperature which lasts about five days. This is accompan-

ied by a coryza and cough; on the third day an eruption is noticeable on the chest and abdomen which may spread to the thighs, arms, and face. There is a typical blood picture, at least in the pre-eruptive stage, in which a leukopenia is found. Koplik spots have been found by some observers in the monkey. Observation would seem to indicate, however, that they do not appear as frequently as in human subjects.

G. H. W.

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INSTRUMENTAL IMPREGNATION.—Dr. E. M. Mosher (*Wom. Med. Jour.*, Oct., 1912) believes that this procedure is a field peculiarly adapted to women in medicine, but should be undertaken only by those accustomed to strictly aseptic methods. Her technic is as follows: "I give careful instructions to my patient regarding the aseptic collection of the seminal fluid. Warm sterile water and a sterile well-covered receptacle (an ointment jar is as good as any other) are placed in readiness in my office dressing room. My patient meets her husband there and brings me the seminal fluid in a warm bath to maintain its temperature. I place her on the operating table, cleanse the vulva and external genitalia as for a curettage, being careful, however, to remove every vestige of soap and disinfectant applied and carefully preventing the passage of fluid into the vagina either in the cleansing process or by douche. The patient is placed in partial Trendelenburg position, the speculum put in place, and the vagina and cervical canal well wiped with cotton. A sound is then passed through the cervix to make sure the canal is open and to ascertain the direction of the uterine cavity at the moment. (Such preparatory treatment as has been found necessary has of course preceded the operation.) With a Braem's intra-uterine syringe the semen is carefully instilled into the uterine cavity. The vagina is filled with the fluid and a 'test tube,' containing very warm water and closed with a cork, is inserted into the vagina a couple of inches to promote by heat the activity of the spermatozoa. After a half hour the test tube is removed and the vaginal injection is repeated. I permit the patient to remain in position an hour or an hour and a half before she goes home. While waiting, I examine the semen, ascertain its degree of alkalinity, and under the microscope observe the degree of activity the sperm cells manifest. As acidity of vaginal mucus and low alkalinity of spermatic fluid are common causes of sterility, I am in the habit of advising my patients who desire children to use a weak boracic acid douche before retiring. When I find that the vaginal secretion is very acid, I apply a tampon made of wool in which a little boric acid has been added dry. This I direct the woman to remove at bed time."—*Internat. Jour. of Surgery.*



## GLEANINGS

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CHRONIC GASTRITIS.—The first essential in considering treatment, says Barclay, naturally it is to determine the etiological factor or factors and as far as possible to correct them. To this end the attention must be directed to a few common points of general hygiene.

I mention them briefly as follows:

1. Prohibition of alcohol.
2. Limitation of tobacco.
3. Appropriate treatment of diseased gums and teeth by a dentist.
4. Exercise regulated to the individual requirements.
5. Sufficient mastication.
6. Regular hours.

In Barclay's experience the best results were obtained by restricting or cutting out the coarse fibred meats, as beef, and prohibiting the use of such scratchy articles as cabbage, raw celery, graham bread, raw fruits, etc. Where atony is present water should not be allowed with meals or its amount limited as the extra bulk acts as a mechanical hindrance to the peristaltic action of the stomach.

In the mechanical treatment lavage is a most useful adjunct. It not only removes the mucus, but in the expansion and contraction of the stomach wall stimulates the unstripped muscle fibres. In the milder degree of gastritis where mucus is not a continuous secretion, washing after a night's fast fails to reveal its presence. In these cases if it is practiced say four hours after an ordinary meal it can usually be demonstrated. The author has never seen that medicated lavage possesses any advantage over plain warm water. The presence of mucus is best shown by splashing a hook around in the washings and if it is present it can be drawn up in white glairy strings. Mere inspection as a rule fails to show its presence, as it is of the same color and held in solution by the water.

A vast host of drugs has been advocated, but the majority of them are useless. In the well nourished cases, with normal or higher acidity use the alkaline saline waters, as Carlsbad in the form of imported salts. What their action is authorities seem to differ, but the general consensus of opinion is that they do exert a beneficial influence on the gastric mucosa by stimulating the secretion of bile, the motor function, dissolving mucus and reducing the acidity. In those cases of less robust constitution vichy salts may be substituted in place of Carlsbad, as its prolonged use is less debilitating. Where hyperacidity exists, the use of alkalis is indicated as soda bicarb. or magnesia oxide.

In the subacid cases Kissengen salts have been advocated and as far as my experience goes, they have proven of benefit, but their use has rested largely on an empirical basis. Recently Van Norden and Dapper have endeavored to determine their true physiological value. Their observations were carried out on a large number of gastric conditions, and one very

interesting conclusion was that in many cases of gastric disorder, especially chronic gastritis, the use of saline waters leads to an active increase in the hydrochloric acid secretion. Again, that in case of hyperacidity a moderate use of the salines tends to decrease the hydrochloric acid secretion. This certainly sounds paradoxical, but the high standing of these clinicians leaves no room for scepticism. When constipation is present, the temperature of the saline should be reduced, as the cooler the water, the more laxative is the effect; where a tendency to diarrhoea is present they should be given as hot as possible, slipping them preferably through a tube.

Those cases where there is no free hydrochloric and a total acidity of 20 or under; hydrochloric by itself or in combination with resorcin, especially where atony is present, is of decided benefit. The Kissengen salts should be given a half hour before meals and the hydrochloric not earlier than half an hour after meals. In those cases where overwork and worry are prominent factors, a trip to some of the European or American spas will often prove of great benefit, not so much on account of the waters, as the regular life, simple diet and the freedom from care.—*Medical Times*.

HOW TO AVOID TAKING COLD.—“I believe,” says Dr. Richard Ellis (*Medical Record*), “I have found a way by which most ‘colds’ can be conquered if fought at their birth. Some years ago a friend said to me, ‘When I feel a strong draught blowing on my bald head I always rub it hard—that brings the blood back, and so I avoid taking cold.’ Later on I noticed that sneezing is always followed by congestion of the face, especially in those who sneeze heartily—that is ‘Nature’s way of bringing the blood back,’ said I, remembering my bald-headed friend. Acting on this principle, I have experimented sufficiently to know that ‘bringing the blood back’ does drive away ‘colds,’ and that sneezing is Nature’s way of restoring (or trying to restore) the normal circulation when a surface anemia has been caused by surface chilling.

“Therefore, when the nasal mucous membrane is first congested, and one feels he is ‘taking cold,’ let him bend the body forward (as in picking up a pin from the floor) and ‘strain’ gently till the face is red, then (in the erect position) try to breathe through the partially occluded nostrils: repeat this process till the nostrils are freely open. Of course one should exercise and take hot drinks till that chilly feeling disappears, but that does not drive away the nasal congestion which so often introduces a severe cold.

“This new method of avoiding ‘colds’ by bringing on forced nasal hyperemia, and following this by patient nasal respiration till the nostrils are freely open, ‘sounds silly,’ but after three years of practical experience, I have decided to publish this brief statement.”

AN OPERATION FOR HERNIA BY A SURGEON ON HIMSELF. According to the *Wiener klin. Wochensch.*, No. 46, 1912, up to the present time only two cases are on record where surgeons have operated on themselves under local anesthesia, although some one was required to inject the anesthetic, as well as to assist in the different steps of the operation. Dr. J. Regnaud, however, conceived the novel plan of operating on himself for inguinal

hernia, and went through the entire procedure, including the anesthesia, without outside help until the application of the dressings. The operative field was disinfected with tincture of iodine and 90 per cent. alcohol. Regnaud then laid down on the table, the upper and lower ends of which were tilted respectively 45 degrees above and below the middle portion, which was horizontal. Local anesthesia was induced by a hypodermic injection of 0.05 morphine into the left arm, followed by an injection of one-half of one per cent. cocaine in saline solution, with addition of 15 drops of adrenalin to 40 ccm., into the layers of the fascia and the hernial ring. Five minutes after the first injection an incision 5 cm. long was made along the course of the inguinal canal. Only the contact of the knife was felt. The hemorrhage was arrested with five clamps and the incision enlarged to 6 cm. After injection of 1 ccm. of the cocaine saline solution into the anterior wall of the hernial canal, the peritoneum was incised, the sac opened up and resected and the hernial opening obliterated by six sutures. The incision in the fascia and skin was then sutured, the skin painted with tincture of iodine and a dressing applied. The duration of the operation was one and one-quarter hours, the total amount of cocaine used being 9 ccm. of the one-half per cent. solution. Coffee was taken at intervals, which the author regards as advisable during cocaine anesthesia. Only the pricks of the needle when injecting morphine and cocaine were perceptible; otherwise there was complete anesthesia without any impairment of the sensorium during the operation. Healing took place by first intention. The possibility of operating upon one's self is an important matter for physicians holding appointments on board of ship or in the colonies where no medical aid is accessible. Regnaud has employed local morphine-cocaine anesthesia for major operative procedures, as in operation for goiter and tumors of the parotid, extirpation of cysts, exploratory laparotomy, excision of the saphena vein, operations for empyema, etc.—*Internat. Jour. of Surgery*.

GYNECOLOGICAL HINTS.—*Ralph Waldo, M. D.*—Unless a careful investigation is made a urethritis is frequently mistaken for cystitis.

One of the most important uses of rubber gloves in gynecological practice is to keep the doctor's hands in good condition.

Granulations or small mucous polypi often form in the lower portion of the urethra and cause frequent and painful urination. They can easily be removed after the free application of a 2 per cent. cocaine solution. As they are usually associated with urethritis this must be cured by appropriate treatment as otherwise the growths will return. Not infrequently Skene's glands are infected and to remove the infection it is usually necessary to incise the small ducts (two in number) leading to them.

Intrauterine medication is a surgical procedure and should rarely if ever be performed in the doctor's office. The practice of applying equal parts of tincture of iodine and carbolic acid with an applicator to the interior of the uterus through a cervical canal that has not been thoroughly dilated has many times resulted in severe burns in the upper part of the vagina.

In the treatment of infection following abortion or delivery at term, when putrid material remains in the uterine cavity, this should first be



thoroughly removed with the finger, blunt curette or forceps. Then an intrauterine douche of a weak antiseptic solution should be given, to be followed by another of sterile saline solution. Tincture of iodine, one ounce to two quarts of sterile water, is one of the best antiseptics to use in the uterus. Repeated intrauterine douches or medication of any kind is injurious to patients suffering from puerperal sepsis.—*International Journal of Surgery.*

A CLINICAL STUDY OF THE ELIMINATION OF PHENOLSULPHONEPHTHALEIN BY THE KIDNEYS, WITH A REPORT OF 150 CASES.—In a careful study of a large number of cases at the Lakeside Hospital, Sanford comes to the following conclusions regarding the value of the phenolsulphonephthalein test:

In view of a considerable experience in the past with other renal functional tests, we consider the phenolsulphonephthalein test as the most valuable means of estimating kidney functions that has yet been introduced, for the following reasons:

1. The rapid appearance of the drug in the urine after administration; in normal cases in from three to five minutes if given intravenously, and in from five to twelve minutes if given intramuscularly.
2. The complete elimination of the drug by the kidney in a short time. It is only necessary to collect the urine after the appearance of the drug for two periods of one-half hour after intravenous administration, and for two periods of one hour after it is given intramuscularly. All other drugs yet introduced for estimating kidney function appear more slowly and require longer time for elimination.
3. The simplicity of technique of the test. The color of the drug is well adapted for exact colorimetric estimation.
4. The accurate indication of renal power which phthalein gives in cases of prostatic obstruction as an aid in deciding the operability of a case. By successive tests in these patients the surgeon can tell if the preliminary treatment is increasing the functional power of the kidneys, and he thus can select a time when operation would promise the best results. He will equally be warned against bad results.
5. The accurate demonstration of the relative efficiency of each kidney which can be secured in surgical kidney cases by comparison of the phthalein elimination of the two sides with the aid of ureteral catheterization.—*The Cleveland Medical Journal.*

THE ABSORPTION OF FOOD IN TYPHOID FEVER.—DuBois in the *Archives of Internal Medicine* makes an interesting contribution to the literature of this subject. He quotes a number of investigations in support of the view that typhoid patients have heretofore been unnecessarily limited as to their food, and then proceeds to detail the so-called "calorie diet" which was administered in the cases which he studied. These patients received a quart of milk, nearly a pint of 20-per-cent. cream, 3 to 6 ounces of lactose, two or three eggs, a couple of slices of toast and some butter, and thereby obtained between two and three thousand calories or heat units, double the amount which they received when upon a milk diet. He even suggests that much good may come from giving such patients boiled rice.

oatmeal, mashed potato, cream of wheat, custard, or ice cream. Many clinicians agree with Du Bois in his views on this subject.

Hare states that there are only three theoretical reasons which can be advanced against it: One, that the patient's digestive apparatus cannot prepare foodstuffs for assimilation while the febrile process is present; another, that there is danger of producing perforation or hemorrhage; and lastly, that the processes of metabolism and assimilation are so perverted that even if a food is predigested the body is unable to benefit by its administration. No evidence has as yet been advanced that these theories are correct. The objection that the digestive functions are impaired has little force because the digestion can be aided by artificial means. The ulcer cannot be perforated by well-softened predigested foods, nor can hemorrhage be produced by such foods, and as to assimilation it can be stated without fear of contradiction that almost invariably typhoid fever patients maintain their weight and are not emaciated at the end of their illness when full feeding is resorted to. The difference between a patient, at the end of the fourth week, who has been well fed and one who has been kept upon a milk diet is almost always one of great degree, and, because of the better nutrition of the well-fed patient, the complications of the later stages of typhoid fever and the sequelæ of that disease are correspondingly diminished.

Du Bois's investigations show that when carbohydrates are given up to 10 ounces a day, careful examination of the stools reveals only traces of them at the very most, and often a total absence, showing that the material has been digested and assimilated. So, too, an examination of the nitrogen of the feces never exceeded amounts which were within normal limits. The only point which is noteworthy seems to be that during the early part of the disease the patient failed to assimilate fat as well as during the third and in the fourth week. He also found that the indican in the urine, which is indicative to some extent of the putrefaction of nitrogenous substances, while high in the early part of the disease decreases steadily as the patient's condition improves, and that it does not materially differ from the quantity found in the stools of normal individuals at any time. Du Bois therefore believes that typhoid fever patients throughout the disease can absorb carbohydrates and protein as well as normal ones, and that they can also absorb a large amount of fat, although the percentage is little lower than normal.

PRESENILITY, A PROBLEM IN PREVENTIVE MEDICINE.—An editorial speaks of the praiseworthiness of the world-wide investigations relating to the prolongation of life and the prevention or amelioration of the infirmities of age. Old age is not only a medical but an economic problem, for it imposes an additional burden upon the community. But while the dependence of the aged is natural and to be expected there is also a tendency in our strenuous civilization to premature senility.

It occurs in those who are still young in years but are physically incapacitated; the race has been too much for them.

How frequently employers refuse work to those who have passed middle age, which necessarily compels the employes to crowd all the work they can into the active years. How frequently employers themselves push

their energies to the utmost in order that they may give up work as early in life as possible.

But to stop bodily activity often means the simultaneous stoppage of mental activity, and death frequently presses closely upon the heels of those who retire from active work.

In presenility the mind may not be greatly impaired, but the skin is atrophic and flabby, the arteries are more or less hardened, the pupils react sluggishly, and parenchymatous tissues are exchanged for fibrous.

The capillaries being thrown out of the circulation there is necessarily an increase in the blood pressure.

The prevention or the deferring of this condition lies in the abandonment of the strenuous life and the substitution for it of the simple life.

There should be regular periods of vacation and periodic relaxation, giving the metabolic processes a chance to pull themselves together. This will result in the resorption of the young connective tissue elements thrown out in reparative efforts but not needed, and before they have become so firmly organized that this is impossible.

The vacation system is really the necessary complement of the strenuous life, the latter compelling its adoption like the occasional laying-up of weather-beaten craft.

This is certainly very fine in theory, but who is going to provide the wherewithal for the vacations when no provision, in anticipation, has been possible? All the world is thinking about this, and one country after another is developing plans whereby the outlook for the sick and the infirm will not be so desolate as it has been in the past.—*New York Medical Journal*.

DIAGNOSIS OF ORGANIC HEART LESIONS.—Bateson gives the following:

1. "In health, the cardiac dullness on percussion, immediately below the nipple, two inches across, and the extent of dullness beyond this measurement commonly indicates either the increased size of the organ or undue distention of the pericardium.

2. "In health, the apex of the heart may be felt and seen to strike the chest between the fifth and sixth ribs, a little below and a little to the inside of the left nipple. Any variations that may exist in the position of the apex are indications of disease, either of the heart itself or of the parts around it.

3. "A friction murmur synchronous with the heart's movements indicates pericardial or epicardial exudation.

4. "A bellows murmur with the first sound, heard loudest over the apex, indicates mitral insufficiency.

5. "A bellows murmur with the second sound, heard loudest at the base, indicates aortic insufficiency.

6. "A bellows murmur with the second sound, heard at the apex is rare. It indicates, first, aortic disease, the murmur being propagated downward to the apex; or, second, roughened auricular surface of the mitral valves; or, third, mitral obstruction (pre-systolic murmur at apex).

7. "A murmur with the first sound loudest at the base, and propagated in the direction of the large arteries, is more common. It indicates, first, an altered condition of the blood, as in anemia; or, second, dilatation or



disease of the aorta itself; or, third, stricture of the aortic orifice, or disease of the aortic valve.

8. "Hypertrophy of the heart may exist independent of any valvular lesion, but this is rare.

9. "The pulse, as a general rule, is soft and irregular in mitral disease, but hard, jerking or regular in aortic disease.

10. "Cerebral symptoms are more marked in aortic disease; pulmonary symptoms in mitral disease."—*Medical Council*.

**AORTIC REGURGITATION.**—Referring to the treatment of this condition Seymour Taylor states that whatever be the cause, the first essential in an early case is complete rest in bed or on a couch. This is more important for the mending of an incompetent aortic valve than for (say) a fractured femur, or even for an aortic aneurism.

Notwithstanding a long period of complete rest after acute rheumatism, it should always be remembered that aortic incompetence may supervene some months later apparent recovery or discharge from hospital and all the time we imagined that the valve was intact.

When aortic valve failure has become a fixed and incurable lesion, other problems arise. Two distinct classes of patients will present themselves for decision. Contrast the man of wealth and leisure with the one who has to work, and possibly labor hard, for his daily bread, and the support of his dependents. Taylor's experience shows that the former lives, on the average, twice as long as the latter.

The pregnant woman should have her parturition eased by instrumental assistance. In every case constipation must be avoided. Alcohol, except in the most diluted strength, should be forbidden. Certain symptoms which are common require palliative measures. These patients suffer from flatulence, both in stomach and in the colon. Therefore fluids should be restricted; food should also be given in small quantities; a fast of one day a week is often of great advantage, as by this means we lessen the heart's toil. It is surely better to take some of the load off the struggling horse rather than to stimulate or goad it to extra exertion. Great relief may be afforded by the passage of a tube into the stomach; but this is a procedure which demands caution. Enemata or a long rectal tube will usually evacuate large quantities of gas from the colon and lower bowel.

Taylor has found great advantage accrue to the patient by prescribing a dietary which shall consist of small meals, in which animal food predominates, the carbohydrates especially being cut down to a minimum. Strong tea, coffee, and any excess in the use of tobacco should be forbidden. The patient should, if his circumstances will allow, have a prolonged rest in bed, with periods of shorter rests from time to time; and even during these rests he should be shut off from all business worries, or mental anxieties which might be calculated to increase the frequency of his cardiac action. By these means not only is the laboring heart afforded the opportunity of self-recuperation, but flatulent indigestion is prevented; for we must remember that the stomach is only next-door neighbor to the heart, and when both organs are distended the distress is a double one, the cardiac being the more urgent.

As regards tonics, Taylor advises the use of such as would be employed

after any debilitating illness. They include iron in small doses, with some bitter infusion, as *nux vomica*.

But this class of case is comparatively rare. The majority of patients who suffer from aortic insufficiency are the victims of some form of toxemia—rheumatic, septicemic, syphilitic. Obviously, if any one of these diseases is present, we shall be assisting in the heart's recovery by prescribing salicylic acid or its compounds, or by ordering mercury, potassium iodide, or both, as the case may be. The treatment is constitutional for the most part.—*The Practitioner*.

A CASE OF CHRONIC MEMBRANOUS CONJUNCTIVITIS TREATED WITH VACCINES.—The author reports a case of membranous conjunctivitis of prolonged chronicity with tendency to leave granulations upon the palpebral conjunctiva, which was treated with vaccines. Other points of distinction are its slight infectivity, superficial nature of the membrane, free bleeding from the conjunctival surface after removal of the membrane, and frequent involvement of the cornea and often loss of the eye.

The Klebs-Loeffler bacillus is most frequently found in membranous conjunctivitis, but it rarely lasts more than a few days, while in the chronic cases a streptococcus is usually responsible.

Six cases resembling the one reported are briefly summarized from literature. In the majority there has been a history of measles, scarlet fever, or whooping cough. The case recorded is of interest from the presence of an influenza-like bacillus, which reappeared in the relapse a year later: this was mixed with what at first appeared to be a pneumococcus, but on further investigation turned out to be a streptococcus.

After ineffectual treatment locally, a vaccine was made, but being given in apparently too large doses, the condition became worse. It was dropped for a time and resumed again with very small doses. This proved effectual, and on a recent relapse taking place some months later, it was employed again and led to the disappearance of the membrane in a few days. Both lachrymal passages were affected with blenorrhœa of both sacs. The cornea of the left eye became infiltrated and sloughed, with resulting shrinking of the eye.

With the disappearance of the membrane protuberant granulations appeared, springing from the conjunctival surface of each lid, which persisted, recurring when excised.

After twenty-six months the condition was little changed, the granulations shrunken somewhat and the discharge less. "How much benefit, if any, in helping to remove and prevent the membrane from recurring was due to vaccine in this case, it is difficult to say, but that the same organisms appeared in the year later relapse as were present originally, and that the membrane gave way on both occasions when the vaccine was given in suitable doses, seems in favor of the therapeutic influence of the vaccine."—*Dr. E. Arthur Dorrill.—Ophthalmoscope*.

WILLIAM SPENCER, M. D.

GLAUCOMA FOLLOWING CATARACT EXTRACTION AND DISSECTION.—A study of these cases and personal observations suggest the following varieties of glaucoma following cataract operation: 1. Glaucoma due to incarceration

of the capsule in the wound, resulting in (a) serous iritis, (b) chronic inflammatory glaucoma. 2. Glaucoma due to immigration of epithelium through the wound of the iris. 3. Glaucoma after discission. As an example of the first variety he publishes the clinical and pathologic findings in one of his cases. There was associated serous iritis. Group (b) includes those cases occurring later after operation, which cases resemble the clinical picture of chronic inflammatory glaucoma. The majority of cases come under this heading. Increased tension seems to follow discission after simple extraction oftener than when performed after combined extraction. These discission glaucomas, however, are seldom followed by serious consequences. They have been attributed to swelling of the lens and traction on the ciliary processes by the luxated capsule (v. Graefe), and to vasomotor irritation with resulting hypersecretion (Bowman).

While glaucoma is more frequent after discission in simple extraction than after the same operation in combined extraction, it is an extremely rare complication, and when it does occur it is of a benign nature. One should, therefore, not be influenced in favor of the combined operation, which is more apt to be followed by glaucoma and by glaucoma of a serious variety. He questions the importance of iris prolapse in the etiology of post-operative glaucoma, referring to Holth's investigations and to Schweigger in support of this view. The incarceration of the capsule is the important factor. This is often favored by the spatula manoeuvre which attempts reposition of the sphincter angles. This inclusion leads to nerve irritation and to hypersecretion.

Extraction should be performed without iridectomy, if iridectomy is absolutely necessary, it should take place after the removal of the lens; or better still, extraction should be followed by a small peripheral iridectomy. He favors scopolamin-morphin anesthesia.—*D. Hanover Staelting.—Graef's Archiv. fur Ophthal.*

WILLIAM SPENCER, M. D.

**AETIOLOGY OF PYOSALPINX.**—From Heynemann's studies of this subject at Veit's clinic at Halle he reaches the conclusion which he tersely states to the effect that more than two thirds of all cases of pyosalpinx are caused by gonococci. Second in importance are septic puerperal processes due mostly to streptococci from which one fourth of the cases result. About one tenth of cases are due to tuberculosis, and only exceptionally are appendicitis and other conditions the cause.—*Zerischr. f. Grb. W. G. Vol. 70-3 870.*

THEODORE J. GRAMM, M. D.

**A PREMONITORY SIGN OF ECLAMPSIA.**—Cammaert found in nine cases paræsthesia of the legs, pruritus and drawing pains in the legs and in the abdomen in whom there was albuminuria and eclampsia, these symptoms not being present in normally pregnant women. From this observation the author suggests that patients having those symptoms should be closely scrutinized for the purpose of determining whether these symptoms are premonitory of eclampsia especially when albuminuria is absent.—*Abstr. Zentralbl. f. Gyn. 1912-760.*

THEODORE J. GRAMM, M. D.



CAMPHORATED OIL IN SURGICAL OPERATIONS.—Lampe uses a 2 per cent. camphorated oil, warmed and sterilized during operations and just before closing the wound, tissues are flooded with the oil and the excess removed with mops. No toxic effect has been observed even in large wounds, and primary union was the usual result. The author has also successfully tried to sterilize the field of operation with camphorated oil, and has found that it has the advantage over iodine tincture, in that the intestines are not injured by the oil, while contact with iodine generally causes the formation of adhesions. Another author has used camphorated oil in suppurating wounds and has found that such wounds rapidly become clean.—*Zentralbl. f. Gyn.* 1912, 633.

THEODORE J. GRAMM, M. D.

AIR EMBOLISM.—Kleinschmidt (Leipzig) has found experimentally that the pulmonary capillaries are not concerned in the ill effects of air embolism, but the damage is done by injury in the right ventricle. When the air is removed all the threatening symptoms disappear. He has also found that in certain positions of the body, that is elevation of the legs, the dangerous symptoms from air embolism may be materially diminished. Meisel has also found that 4 ccm. of air is a fatal dose, and when the animal was placed horizontally it became breathless, but when raised vertically the dangerous symptoms immediately disappeared. The same experience occurred in a patient where this dangerous accident had happened.—*Zentralbl. f. Gyn.* 1912-634.

THEODORE J. GRAMM, M. D.

THE DIAGNOSIS OF URETERAL CALCULUS.—Casper (Berlin) says the subjective symptoms are renal colic, painful urging to urinate, sense of pressure in the region of the stone. But these symptoms may also be absent. The diagnosis is probably rarely made by palpation. Examination of the urine is important. The author has observed that blood and hyaline casts are not only found in nephritis, but especially in ureteral calculus. Catheterization of the ureters may lead to the diagnosis. It is noteworthy that various derangements of renal function may occur, but may also be absent. The X-ray is of course valuable, but we must not be misled by shadows in the pelvis, phleboliths, calcareous glands and exostoses of the pelvic bones. For a certain diagnosis the author recommends to pass a ureteral catheter provided with a metal mandarin. The X-ray picture will then show whether the stone is in the ureter or not, for shadows in the pelvis generally lie outside the region of the sound. If they lie along the course of the sound, another photograph taken from a different angle will aid in the diagnosis. The author does not advise to operate at once. From the injection of glycerin into the ureter through the sound armed with an inflatable balloon the author has succeeded in bringing about a cure. If this prove unsuccessful the case is operated, extraperitoneally.—*Abstr. Zentralbl. f. Gyn.* 1912-1196. 3.

THEODORE J. GRAMM, M. D.

ORIGIN OF PUERPERAL MASTITIS.—Lindemann and Noack say at Veit's clinic in Halle the view has been accepted that puerperal mastitis often

arises from germs growing in the vaginal secretion of the mother, which have primarily entered the mouth of the infant and thus reached the nipple of the mother. Cultures made from cases of mastitis, of stomatitis, vulvitis, mastitis neonatorum and also from the mouth of children who have not yet nursed, have shown the probable course of the infection. In two cases of puerperal mastitis hæmolytic staphylococcus pyogenes aureus were found in almost pure culture in the maternal vaginal secretion. In other cases the infecting germs were traced in the same way. Practically these studies indicate the urgent requirement of cleansing the infant's mouth before nursing, and also actively treating abrasions of the nipple in order to prevent, if possible, an infection whose route and source is demonstrated.—*Zentralbl. f. Gyn.* 1912-91.

THEODORE J. GRAMM, M. D.

MANAGEMENT OF THE THIRD STAGE OF LABOR.—Reich (Innsbruck) has published an excellent article on the management of the third stage of labor. He reviews the several methods usually practiced and comes to the conclusion that the so-called English or Dublin method has many advantages in the majority of cases, and is the one which merits the consideration especially of the general practitioner. It consists mainly in "holding the uterus." The author is led to give his especial favor to this method from his observations of the physiological comportment of the uterus when the organ was exposed to view during his Cæsaeran sections. In the practice of this method the hand is placed upon the abdomen and the corpus uteri grasped and held or supported without much massage or compression. These procedures are however at once available if they become necessary for any cause; and the same may be said of the expression of the placenta as suggested by Crede. This support and aiding of the uterus in a physiological manner after the expulsion of the child has been practically shown to result in the spontaneous expulsion of the placenta and in a greatly diminished loss of blood so that the subsequent course of the puerperium is quite favorably influenced.—*Zentralbl. f. Gyn.* 1912- 977.

THEODORE J. GRAMM, M. D.

POST-OPERATIVE CYSTITIS. Brocks (Erlangen) has reported 40 cases of post-operative cystitis following 200 gynecological operations. The causes he ascribes to catheterization for retention; direct injury of the bladder during operation; injuries to the bladder and ureters which may secondarily lead to fistulæ; infection of the tissues surrounding the bladder; germs ascending to the bladder through the urethra; and bladder or kidney lesions existing prior to operation. The conclusions reached are that the injury to the bladder in its blood supply and innervation is not the direct cause of post-operative cystitis, but is only the prerequisite for its occurrence. Infection must be added. The possibility of infectious germs gaining access must be sought to be avoided by limiting catheterization, and the patient induced to void urine spontaneously. The strictest asepsis must be practiced in the use of the catheter. During operation crushing and injuries of the bladder and of the ureters must be avoided. Infection of the tissues surrounding the bladder must also be prevented during operation.—*Zentralbl. f. Gyn.* 1912-1229.

THEODORE J. GRAMM, M. D.

**PUERPERAL THROMBOSIS AND EMBOLISM.**—Thrombosis has received much attention abroad. Another study, by Jung (Strasburg) has led him to the conclusions that the determining factor of puerperal thrombosis is, besides the circulatory disturbances, the injury to the endothelium of the vessel wall. Such endothelial injuries are constantly present in phlebec-tosios, which are externally present in 26 per cent. of all pregnancies, and in 71 per cent. of multiparæ. This corresponds with the frequency of occurrence of puerperal thrombosis in multiparæ, 72 per cent. of whom have varices, especially in middle life. Disease of the saphenous veins occurs mostly in the earlier part of the puerperium; in the femoral veins in the latter part of the puerperium; while the pelvic veins are affected during the middle of that period. Both sides are equally affected, but the saphenous vein on the right side is mostly involved, while thrombosis of the femoral veins is often left sided. The predisposing causes especially in multiparæ with varices, are obstetric operations, hemorrhages, infections, general diseases and prolonged second stage of labor. One attack predisposes to another. In the beginning the attack may be accompanied by mild fever. There are no premonitory symptoms. Saphrenous throm-boses have usually a good prognosis, while when the deeper veins are affected, there is, of course, some doubt, because of the danger of pul-monary embolism.—*Arch. f. Gyn. Vol. 96-356.*

THEODORE J. GRAMM, M. D.

**PSYCHOPATHY AND GYNECOLOGICAL DISEASES.**—Possi (Genoa) says that just as psychic disturbances may arise in consequence of alcoholism, syphilis, typhoid, etc., so also may they be seen as the consequences of tox-æmias from concealed foci in the female as well as in the male genitalia, in the intestinal tract and in the ear. Such disturbances with torpor and anomalies in tissue changes from deranged internal secretion of various glands, may develop both in men and in women. This opinion, he con-cedes, is not new but he believes we have not practically applied it. The author has found that it is not the serious gynecological diseases, like fibroma, cysts, carcinomata and hematoceles which usually cause psychic manifestations, but rather the infectious and toxic diseases of the endo-metrium, with slow and often concealed course, the parenchymal forms of functional and infectious origin. The effects of such lesions is the more serious when to them is added stenosis of the cervical canal with flexions of the uterus, leading to stasis in the uterus and consequent absorption. Nervous and psychic disturbances frequently arise when to the above named lesions menstrual disturbances are added. Of course he does not ignore the influence of heredity, early training, family environment, and other circumstances. Several cases are cited to substantiate these views, and the results of treatment also confirm them. The author advocates the treatment of gynecological lesions in the insane, and believes that thereby we may also exert a certain prophylaxis against insanity.—*Zen-tralbl. f. Gyn. 1912-1213.*

THEODORE J. GRAMM, M. D.



## Monthly Retrospect

### OF HOMOEOPATHIC MATERIA MEDICA AND THERAPEUTICS

CONDUCTED BY A. LEIGHT MONROE,

Miami, Florida.

**SOME CHARACTERISTICS.**—By *M. E. Douglass, M. D., Baltimore, Md.*—*Abrotanum*.—Cross, irritable children, with evident signs of chlorosis or emaciation; appetite is ravenous, yet child loses flesh (Iod., Nat. m.; Calc., Ph., child wants to nurse all the time, loses flesh, cannot stand; Cina, child is cross, weeps, has great hunger, pale, sickly face, but less emaciated). Food passes undigested; face looks wrinkled as if old. Creos., Sulph.; Opium the suckling of a few weeks does not grow, but looks like an old man.) Weak, cannot hold head up. (Also Aeth., Ant. t., Arn., Bapt., Lyco., Mang., Puls., Oleand., Sil., Tabac., Zinc.) Boys with nose bleeding or hydrocele. Blood and moisture oozing from navel of new-born children.

Rheumatic pains, lame and sore, worse morning on waking (Bry.). Hemorrhoids, burning when touched or during stool. (From touch: Phos., Sulph.; during stool: Cocs. c.; relieved by stool: Caust.; worse after stool: Berb., Nit. acid.) Hemorrhoids become worse as rheumatism abates. (Lumbago alternating with headache or with piles: Aloe.)

In children, after influenza, great weakness and prostration and a kind of hectic fever (compare Samb. and Senega). The pains in stomach are worse at night; rheumatic pains are worse on moving and morning on waking.

**Acetic Acid.**—Aconite has been frequently administered in cases where acetic acid was the proper remedy. The acetic acid patient is pale, emaciated; seldom or never fat, and of a waxen color; its mental state is apt to be one of anxiety—worry about sickness or affairs—and irritability. The aconite symptoms appear suddenly and are violent (the reverse of acetic acid); the patient is not pale or emaciated; rather red, florid, and plethoric; is anxious, that is, fearful, timid, afraid he will die, afraid of everything, is restless. Both aconite and acetic acid have thirst, the latter very markedly, and here it differs from apis. Apis patient is also pale, waxen, but more apt to be puffed in appearance than emaciated. In dropsies the emaciation and thirst of acetic acid differ from the puffed, swollen face and the lack of thirst of apis. Acetic acid has a nervous headache from abuse of narcotics; from abuse of alcohol, coffee, opium or tobacco. (Asarum, Caladium.) Pain across root of tongue, impending speech and motion of jaw. (Sulphur: dull pain in root of tongue, worse evening, obstructing speech.)

Thirst intense, insatiable; cries loudly for water at night, notwithstanding

ing has drunk copiously. In dropsies, diabetes insipidus, chronic diarrhœa, greatest thirst; in fevers there is no thirst.

In croup there is a hissing respiration, with rattling in throat, worse at each inhalation. (Aconite at each exhalation). A white film low down in fauces.

If thirsty, water is swallowed with difficulty. Hydrophobia patient springs out of bed and crawls on the floor howling with pain. (Arsenic, rolls about the floor with despair of life from pain in abdomen.)

Patient cannot sleep lying on back, feels as if abdomen were sinking in, causing difficult breathing; rest easier lying on abdomen. Sleep is poor, is disturbed without known cause.

Hemorrhages from nose, lungs, bowels, hemorrhoids, uterus, etc., in debilitated, pale, thin persons with a waxy appearance. Is useful after stings, bites, etc.

*Rhododendron and Rhus.*—Both remedies have rheumatic pains, especially in all the aponeuroses; worse when at rest; worse at night.

*Rhododendron* pains do not admit of the limbs being at rest; desire to move, and moving relieves.

In *Rhus* rest occasions uneasiness in the painful parts, but on moving, the pain is worse. Continued motion only relieves.

*Rhododendron* has general aggravation of pains before a change in the weather—particularly before a thunder storm—even in dysentery indicated by this.

*Rhus* has aggravation from the warmth of the bed, and as a general characteristic in consequence of stretching, over lifting, over exertion of joints, etc., or from getting wet while perspiring.

*Rhododendron* has aggravation of pains in the night, but more toward morning; *Rhus*, more toward evening and night.

*Rhus* corresponds to rheumatism in the cold season; *Rhododendron* in the hot season. *Rhododendron* worse before and *Rhus* worse after rain.

*Stramonium.*—Vertigo, when walking in the *dark*, day or night. When walking in the dark at night, he staggers and falls down every time he attempts to walk. The same occurrence transpires when he attempts to walk in a darkened room in the daytime.

Young men are cured, as well as young women, when they pray, sing, or talk in a very devout, earnest, and constant manner, so as to excite the sympathy of all in the house.

In typhus, typhoid, or other fevers, when the patient frequently raises or jerks the head from the pillow. An old keynote, and sure; one of the most characteristic.

All sorts of strange and absurd ideas, such as the patient is double and is lying crosswise.

*Actea Racemosa.*—This drug is especially suitable for nervous females, tall, dark complexioned, and subject to rheumatic and uterine troubles, resembling in this latter respect caulophyllin and sepia; and in neuralgia and rheumatism, belladonna and *rhus*, which are complementary. Its action on the male organism is more analogous to that of *bryonia*. In alcoholism and delirium tremens *Actea* is indicated when the patient has a frightened look and changes rapidly from subject to subject. Like *lachesis*, *rhus* and *tuja* it affects especially the left side, like *belladonna* the upper dorsal

spines; and like belladonna, bryonia and rhus the lumbar muscles. Characteristic indications are: Sleeplessness, sensitiveness to draughts of air (China), sinking at epigastrium; palpitation, especially after full meal or over exertion; left sided prosopalgia (*Colocynthis*, *Mercurius biniodide*. *Mezereum* and *Spigelia*). Tongue clean, but pointed, as in rhus; frequent ejaculatory sighs; short, dry cough; leucorrhoea (post-menstrual). Rhus or sepia follows well.

*Baptisa Tinctoria*.—Live *veratrum viride*, which it resembles in some respects, this drug will, doubtless, be better appreciated as its true range of usefulness becomes better known.

In the early stages of typhoid fever *gelsemium* and *veratrum viride*, belladonna, bryonia, arnica and rhus seem to compete with baptisia. It seems to be especially applicable to diseases of a septic nature or origin, in which fetor and great prostration are prominent features. Hence its reported success in diphtheria and diphtheritic croup. In this marked prostration its analogies are notably *arsenicum*, *gelsemium* and *rhus toxicodendron*. In the appearance of the tongue, and in the "sore, bruised feeling," it resembles arnica. We turn to the mental symptoms for a distinction. The arnica patient says "there is nothing the matter" with him, or else "he forgets the word while speaking." The baptisia patient either "falls asleep in the midst of a sentence" or "he cannot sleep because his head feels as though it was scattered about." In some symptoms it also somewhat resembles *actea racemosa*.

*Caulophyllum*.—This remedy suits all, slender females (*Phosphorus*) who are of a dark complexion and are inclined to rheumatism (*Actea*). Its peculiar affinity for the uterus is well known. No less remarkable is its relation to rheumatic affections of the wrist and finger joints, especially of the right hand (*Viola odorata*). The swelling of the finger joints is pale; pains worse every other evening and on attempting to close the hands. As in *kali bichromicum*, rheumatism and gastric symptoms alternate, so here rheumatism may alternate with asthmatic attacks, where *kali carbonicum* and *phosphoricum* may also be required.—*Medical Century*, Jan., 1913.

SOME NOTES ON GELSEMIUM. *Henry R. Stout, M. D., Jacksonville, Fla.*—This is one of the most valuable remedies in our *Materia Medica*. The vine is a native of the Southern States; is evergreen, and in its blooming season, in March and April, is thickly covered with yellow blossoms, very fragrant, from which a delightful perfume is made.

In the preparation of the plant for medicinal purposes the inner bark of the fibrous roots is used.

In cases of poisoning the most marked characteristic is paralysis of the motor nerves, acting on the cerebro-spinal system. The mind becomes sluggish, the sphincters become relaxed, causing involuntary urination and defecation; the muscles of the chest become paralyzed, causing very labored breathing. I once made an unintentional proving by taking six drops of the 2x dilution, on retiring at night, to break up a catarrhal attack with which I was threatened.

On waking in the morning, I felt hardly able to get out of bed. It was necessary, however, that I should attend to my practice, so I made my usual visits. I noticed that in going up stairs, or in getting into my buggy, that



I had difficulty in moving my legs. My feet were heavy; I had difficulty in breathing, but was surprised to notice that the bronchial tubes were quite free from mucus.

It then occurred to me that I was suffering from a poisonous dose of the drug. These symptoms gradually wore off during the day, and the influenza at the same time.

This proving, however, served to turn my attention to the value of the drug, and I consider it one of my most valuable remedies.

In accordance with its paralytic action, it causes double vision, by paralyzing the muscles of the eye; it also causes paralysis of the upper eyelid. The eyeballs are sore, worse on moving the eyes, this being similar to bryonia.

It also, through causing a paralysis of the muscles of the throat, causes difficulty of swallowing. In paralysis of muscles of deglutition following diphtheria think also of stannum met.

Several years ago I was consulted by an allopathic physician, who had come to Florida for his health. He was suffering from this symptom, which followed an attack of diphtheria. This condition had lasted two or three months.

In connection with the throat symptoms, was a weakened heart action. I gave him the 3x potency, and he was entirely relieved in less than a week. He considered it a miraculous cure, and promised to investigate homœopathy.

The headache of gelsemium begins in the nape of the neck, passes over the head, and locates in the eyes; the head will sometimes feel too large.

I have found it very useful in the depression of the system caused by the heat of summer.

The person will feel hardly able to move; the mind is sluggish, and there is a great disinclination to make any exertion.

It is of the greatest value in malarial fevers, of either the remitting or intermitting type; it is particularly valuable in the remitting type of fever in children.

The intermittent type of fever is characterized by the absence of chill; it has regular periodicity, every day at the same hour. The period between attacks is short, verging on the continued or remittent type; there will be great prostration of the whole nervous system.

In typhoid it is particularly useful in the early stage, during the first week, especially if the patient feels sore all over, great prostration and drowsiness.

It is very useful in the beginning of a catarrhal attack, characterized by sneezing, with profuse watery discharge from the nose, which may be excoriating; the throat may also be sore and tonsils swollen.

In neuralgia of the seventh pair of nerves it is an important remedy. In prolonged labor, due to a rigid os uteri, this remedy will usually act promptly to cause relaxation.—*Medical Century, Jan., 1912.*

**SELENIUM IN HYDROCELE.**—A case of hydrocele in a man aged 44, which had existed since childhood, disappeared upon taking selenium 6 for seminal weakness. Another case in a man of 55. Selenium diminished the size of the hydrocele by a quarter in three months. In a child with a slight hydrocele selenium cured completely in a month.—*L. Art Medical.*

# THE HAHNEMANNIAN MONTHLY.

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APRIL, 1913

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## CLINICAL ANALYSIS AND PATHOLOGIC FINDINGS OF AN UNUSUAL CASE.

BY

CHARLES D. FOX, M. D., PHILADELPHIA.

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(Read before the Clinico-Pathologic Society of Philadelphia, February 15, 1913.)

IN all branches of medicine mistaken diagnoses are not uncommon. Autopsies of carefully studied cases reveal only too frequently the absolute fallacy of what were looked upon as clean cut diagnoses of text book varieties of syndromes. Selecting at random a few of the diseases considered in a recent paper by Cabot (*Journal of the American Medical Association*, Vol. LIX, p. 2295), based on the study of 3,000 autopsies, we find that such conditions as acute pericarditis, thoracic aneurysm, active phthisis, and brain hemorrhage were successfully recognized during life in only 20, 50, 59 and 67 per cent., respectively. Consequently, in view of the recognized frequency of mistaken diagnoses and for the purpose of educating ourselves we should strive to obtain autopsies in all fatal cases.

Believing that the description of a case in which the diagnosis was incorrect is often more instructive than the usual method of reporting our successes the following study is presented to this Society:

The patient, a girl of 12 years, was well until February,

1909, when pains commenced in all of her limbs. One joint after another was involved without intermission; the condition still being present, but to a lesser degree, when the patient was first seen by me, January 9, 1910. Following the onset of the joint pains the patient frequently developed purpuric areas which lasted several days or longer, and which were as large as two inches in diameter.

October 23, 1909, after passing through what, to her, was a trying ordeal—an examination in arithmetic—the patient complained of numbness and tingling in the right side together with paralysis of the same side. She had not fallen or become unconscious. Soon after the onset pain was said to have been caused in the right leg when a physician pricked the numb left one. The hemiplegia was severe enough to compel the patient to remain in bed or on a lounge. The patient had always been a nervous and excitable child, but after the hemiplegic attack she became apathetic and indifferent.

January 1, 1910, Dr. William Hayes Brown was called to attend the patient because of the development of attacks of epistaxis and other more grave symptoms. He found complete paralysis of the left third nerve, severe headache, increasing stupor, urinary retention, difficulty in swallowing, and a temperature of 100 degrees.

Having been called in consultation, January 9, 1910, I found almost total paralysis of the left third and fourth nerves and partial paralysis of the same nerves on the right side. The jaws were locked and the limbs appeared to be incompletely paralyzed, but there was not any marked spasticity even though Kernig's sign, the Babinski reflex, and ankle clonus were present in both lower extremities. While the ankle clonus was not sustained for more than a few seconds at a time it was typically organic in other respects. The patellar reflexes could not be elicited. There was not any atrophy. Though stuporous the patient appeared to suffer from severe headache and she was irritable. During the afternoon projectile vomiting and involuntary urination appeared.

The following day the patient entered Hahnemann Hospital, and, because of her age, was assigned to the paediatric service. Lumbar puncture, performed by Dr. Raue, showed the cerebrospinal fluid to be clear and not increased in quantity. Dr. Eaches found the fundi normal. The stupor gradually increased and spasticity, paroxysmal risus sardonicus, and bed sores



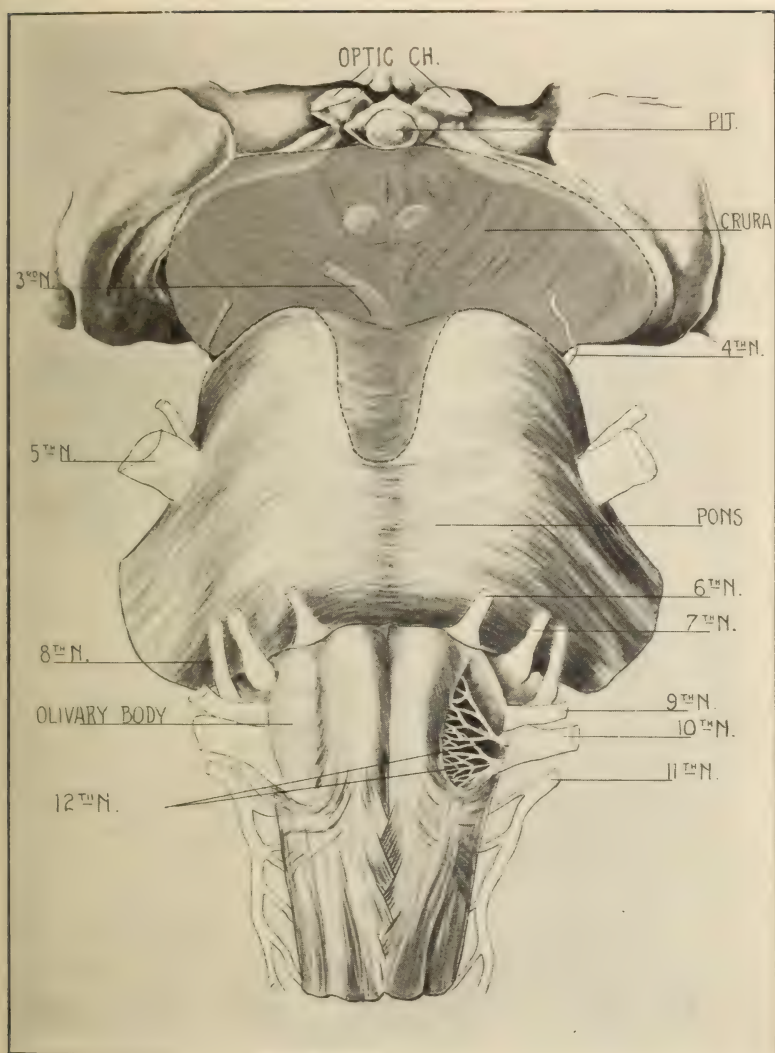


FIG. I.—Dotted lines enclosing shaded area indicate size and position of the blood clot as it pressed upon the optic thalamus, crura and upper portion of the pons.

soon appeared. As the end approached Cheyne-Stokes respiration developed and the patient died from exhaustion January 29.

Summarizing the symptoms we find the patient had suddenly been afflicted with right hemiplegia, and that a little over two months later the left third nerve became paralyzed—crossed hemiplegia. A few days later we noticed the appearance of almost total paralysis of the left fourth nerve, in addition to the third one, and partial paralysis of the same nerves on the right side. The presence, at this time, of ankle clonus, the Babinski reflex, and Kernig's sign in both lower extremities pointed to a bilateral lesion of the upper motor neuron. Taken as a whole, the symptoms indicated a lesion beginning in the left cerebral peduncle and enlarging sufficiently to involve the right one. Such a lesion would produce right hemiplegia with paralysis of the left third and fourth nerves followed by similar implication of the same ocular nerves on the right side together with left hemiplegia—double crossed hemiplegia.

The progressive development of apathy and stupor, intense headache, irritability, and projectile vomiting, together with the mode of onset of the paralytic symptoms, seemed to indicate a moderately rapidly growing tumor. Accordingly I made the diagnosis inoperable brain tumor—inoperable because it was rather late to operate upon a tumor of this region large enough to cause the symptoms she possessed, and even a very small tumor of the cerebral peduncles in a favorable case would be both difficult and exceedingly dangerous to operate.

Now, let us see how the results of an autopsy upset all this logical reasoning. In the left optic thalamus there is a small hemorrhagic lesion that appears to be at least several months old, and, resting on the anterior surface of the crura and upper anterior border of the pons, a recent subpial blood clot about one inch wide by  $\frac{7}{8}$  of an inch in length and  $\frac{1}{2}$  inch in thickness.

With the light afforded by these pathologic findings we can examine the history with renewed interest. The symptoms fall naturally into three groups. The first is the period of arthritic pains and purpura; the second, the period of simple right hemiplegia resulting from a small hemorrhage in the left optic thalamus; and the third, the period of crural and pontine hemorrhage. This second intra-cranial hemorrhage caus-

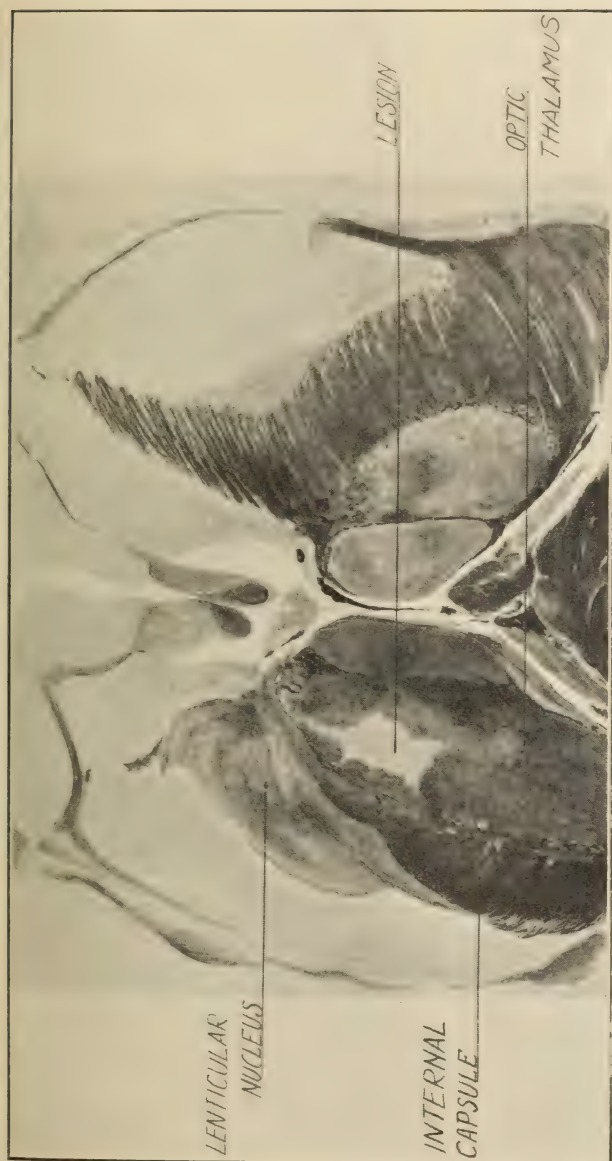


FIG. II.—Showing the old hemorrhagic lesion in the optic thalamus.



ed the formation of a thick clot which pressed directly upon the pyramids—the motor pathway—of the crura thereby producing symptoms of double hemiplegia. The third and fourth nerves, being given off from the crura, were affected by the clot. The patient exhibited paralysis of the left third and fourth nerves and paresis of the same nerves on the right side. On examining the specimen it was found that the right third and fourth and the left fourth nerves were shriveled up while the left third nerve could not even be found. In view of the fact that the clot rested upon both optic tracts fundus changes should have appeared and, had the patient been sufficiently conscious to have made perimetric examination possible, no doubt the visual fields would have been found abnormal.

It is a good rule never to diagnose two lesions of the central nervous system when all the manifestations present in a given case can be just as satisfactorily explained on the basis of one lesion. In this case, however, we find that though the symptoms at first were typical of crossed hemiplegia due to a crural lesion yet, in reality, two distinct hemorrhages were present. I know of another case which was identical with this one in many respects. The patient had aphasia and right hemiplegia, due to a tumor of Wernicke's zone, followed by the appearance of paralysis of the left ocular muscles in consequence of a metastatic growth in the pyramids of the crura and pons.

With the data afforded by the clinical history and the pathologic material we may now revise the diagnosis: peliosis rheumatica complicated by a hemorrhage in the left optic thalamus and followed by a subpial hemorrhage which compressed the anterior surfaces of the cerebral peduncles and part of the pons.

As peliosis rheumatica is not a common disease allow me to introduce a few remarks. Schönlein's disease, or peliosis rheumatica, is a clinical syndrome characterized by purpura and urticaria in association with arthritic symptoms which are usually less severe than those of attacks of acute rheumatism. It occurs usually in adults and lasts a few weeks though relapses are frequent and may prolong the condition for months. It may be accompanied by mild constitutional disturbances such as slight fever, anorexia, and indisposition.

The causes of purpura are as follows: 1. The acute infectious diseases. 2. Prolonged wasting diseases, such as tuberculosis and malignant tumors. 3. Intoxication with such substances

as phosphorus, potassium iodide, mercury, quinine, belladonna, and snake venom. 4. Mechanically in pertussis and epilepsy. 5. Certain nervous diseases, such as tabes, myelitis and hysteria.

The pathology of purpura is practically unknown and probably more than one disease is included in the term. Purpura simplex is characterized by petechiae lasting several weeks. Purpura hemorrhagica is a considerably more severe form of the affection and is distinguished by the occurrence of hemorrhages from the mucous membranes. The disease may attack a person at any age, and it may last for months. Its gravity is shown by the forty deaths occurring in a series, collected by Steffens, of 128 cases of all varieties of the disease in children.

In view of the fact that the patient, whose case is reported in this paper, had suffered from arthritic pains and purpuric spots in the skin followed by the onset of sudden hemiplegia and later by the development of double hemiplegic symptoms in association with repeated attacks of epistaxis, it may be wondered that the proper diagnosis was not made when I first saw the patient. To discount what seems so obvious when one knows the pathologic findings it must be remembered that the occurrence of intracranial hemorrhage as a complication of peliosis rheumatica is very rare, and that while the type of purpura in this case was very severe, as demonstrated by the intracranial hemorrhages and attacks of epistaxis, yet the symptoms of peliosis rheumatica were not prominent. Thus, when I saw the patient neither rheumatic symptoms nor purpura were in evidence. On the other hand, the manifestations were most suggestive of a rapidly growing brain tumor.

I am indebted to Dr. John G. Wurtz for the excellent illustrations which accompany this paper.

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THE OPERATIVE TREATMENT OF CANCER OF THE BREAST.—By Alfred de Roulet (*American Journal of Surgery*, March, 1913).—Radical operation is the only treatment for cancer of the breast offering the slightest hope of permanent relief. All other forms of treatment are at best palliative and their employment in any but hopeless cases cannot be too strongly condemned. Even the radical operation is usually futile in the presence of (a) fixation of tumor to skin; (b) ulceration or extensive infiltration of overlying skin; (c) extensive involvement of axillary glands; (d) palpable invasion of supraclavicular glands; (e) visceral or osseous metastases; (f) involvement of both breasts.

## MY PLAN FOR PLACING HOMŒOPATHY ON A PROPER BASIS AS THE SCIENTIFIC THERAPEUTIC RESOURCE OF MEDICINE.

BY

FRANK F. CASSEDAY, PH. B., M. D., PORTLAND, OREGON.

(Read and endorsed by the Round Table of Homœopathic Physicians of Portland, Oregon.)

ALL great movements for the betterment of mankind, if vigorously pushed at the psychological moment, secure an impetus which carries them to successful issue.

Homœopathy as an organized movement to cure disease has been in the doldrums for the past ten years.

Homœopathic colleges are losing students, homœopathic departments in State universities are being thrown out by the pernicious political activity of the old school enemies of homœopathy, homœopathic physicians are allying themselves with old school medical societies (being hugged to death by the old school organizations as a witty old school physician of Canada aptly puts it), and the younger men are joining old school societies in large numbers and abandoning the use of remedies selected according to the law of similars.

Homœopathic physicians are fighting among themselves, cliques in cities exhaust themselves fighting each other over silly inconsequential matters, while the common enemy, the old school doctors and organizations, are driving in the outposts and breaking down the homœopathic organization by every means, fair or foul, in their power. They win over the homœopathic physician by flattery and cajolerie, and after he is brought into camp he is hugged to death.

Homœopathic societies have a small membership; their numbers show little enthusiasm over homœopathy, and seem to act on their own initiative with fear and trembling lest the scorn of old school physicians will make them pariahs of medicine. They have wish bones where their back bones ought to be. They shilly-shally. They lack the courage of their convictions if they ever had any about homœopathy.

Is the time ripe for homœopathic physicians to declare themselves boldly before the world? Is the law just as true as it was in Hahnemann's day? Is there a working method by which it can be accomplished so that homœopathy can be placed



on a proper basis before the entire world of laymen as the only scientific therapeutic resource of medicine? To all of these I answer, yes.

Let us see. The old school has laid down on the job. They declare flatly that there is no efficacy or merit or curative properties in drugs administered internally. Practically all old school physicians ignore special therapeutics with the exception of iodides and mercury for syphilis and quinine for fevers. The patients of old school physicians are drifting away to the religious cults, except those who go to homœopathic physicians who are holding up the banner of homœopathy as individuals. The old school is clutching at every will-o'-wisp which promises help as a specific, only to give them up as new promoted specifics loom up on the horizon. The modern method of placing so-called specifics on the market by foreigners through the free utilization of the press agencies is the smoothest and the cheapest method of patent and secret medicine advertising the world has ever seen. It has American advertising of patent medicine beaten to a frazzle. And the funny part of it is that the wise old school doctors fall for it and fall all over each other to beat one another to it; meanwhile waving their money in the air and anxious to give it away (the money). Every scientific demonstration and discovery made in the great fields of collateral science like astronomy, industrial chemistry, physics, and experimental physiology are slowly but surely consigning their theories to the graveyard of medical fads. The germ theory is an unstable ground and will probably be discarded as the field of demonstrable activity of matter is widened by the spectroscope, the ultra microscope, and other instruments of precision. Carrell, in his physiological experiments, announced a few days ago in referring to the fluids for promoting healing of wounds, that the fluid from the dog heals the wound on the dog, but not on the man. The fluid from the guinea pig heals the guinea pig, but not the dog, and vice versa. The fluid from the horse will heal the wound on the horse but not the wound on the man. That is a body blow at the whole theory of serums from animals for human ailments, and adds more force to the theory that the body contains within itself a chemical laboratory which, if properly reinforced by wise administration of drugs, will do the work.

This is the condition of the medical field to-day.

The law of cure is just as true to-day as ever, and investigations in all experimental fields of science emphasize it.

Shall we sit quietly and allow the old school pirates to steal homœopathy and the law, re-label it, and place it before the world as a newly discovered law? They will do it as sure as we are living men, and if we do not bestir ourselves the ground will be cut from under us, and we will be left stranded.

Now as to my plan.

Did you ever know of any great movement, even if it has merit, which succeeds in enrolling adherents in large numbers without systematic campaign of publicity? Truth has no inherent power to succeed. Christianity did not become the religion of the civilized world on account of its truth. It came to its present growth and power by incessant work, and war, and the shedding of human blood in streams.

Look at the Mormon church, and the Christian Science church. They are both religious cults and they have the greatest and most complete system of propagandism and proselyting the world has ever seen. The Christian Science church has a bureau of publicity with its head in Boston, and a representative in every considerable town who answers adverse criticism of the cult, and leads the systematic dissemination of the doctrines and by the most insinuating and persuasive methods breaks down opposition and at the same time secures converts to the faith. The head of the publicity bureau in Boston receives a copy of every publication and every clipping which bears on Christian Science in any way especially adverse criticism. These clippings and papers are supplied by a clipping bureau. These are filed and every newspaper or publication criticising Christian Science adversely or making statements about the cult which are incomplete or wrong, though they may not be inspired by enmity or malice, are promptly mailed matter about the cult in handy form for reprinting, accompanied by a personal letter offering the matter as news material. Later brief explanatory articles or articles answering adverse criticism are mailed to these papers signed by the head of the department as a private individual. This complete system is supplemented by lecturers who lecture every year in the principal cities explaining the doctrines of the cult and proselyting for members. It is the most complete and perfect working system of publicity the world has ever produced, and it produces the results.

Homœopathy needs publicity. New generations of people are coming into maturity, who know absolutely nothing about homœopathy, except in a very vague and indefinite way. Old school physicians encourage this by saying there is no difference in the schools to-day, and much more of that line of rot. Physicians have long since ceased to hold themselves out as homœopathic physicians. Is it any wonder homœopathy is dying, slowly dying? If the adherents and practitioners of homœopathy are either ashamed or afraid to publicly declare themselves it is folly to expect the daily and monthly press of the country to take homœopathy seriously. In this generation and in these times it is only active, militant organizations who carry on aggressive campaigns of publicity which will survive or secure supporters.

My plan is a perfected publicity campaign to reach the laity.

This should centre in the board of trustees of the American Institute of Homœopathy, or a large sub-committee of the same board.

This should be arranged as follows:

1. Eliminate the traveling organizer to meet the doctors. There is no need of such a man, as this work can be done better by local men, and the money paid such a man and his expenses will provide funds for the Central Publicity Bureau.

2. A Central Publicity Bureau with a live man in charge, either the man in charge of the entire campaign, or a special man with a faculty for writing medical truths in popular language.

3. A press department. A sub-department of the Central Publicity Bureau. This department to prepare and send regularly to lists of papers and magazines—classified in a card index, live matter relating to all departments of health and referring to the methods and practice of homœopathy, the good it has accomplished, the lives it saves, the organized institutions of homœopathy, etc., all sent out on slips under proper headings, some short articles and some more extensive, ready for reprinting in newspapers and magazines. Good matter will be received with approval and published, and soon the editors will take notice that there is a great national organization behind the movement, and that it means something for humanity. In addition to publishing the notices sent to the editor month after month and year after year, he (the editor) will presently begin to write editorials about it. This campaign of education of the



editors and through them of the laity will lead up to the final plan for :

4. Public lectures by physicians in all the principal towns and cities of the country. Here is where the plan touches the laity and the doctor and brings them together. The head publicity bureau sends out the literature to the papers, and also sends slips telling of the advantages of homœopathy with comparative statistics free to the doctors, and he in turn mails these to such persons as he desires, enclosing his card therewith. The lectures will be given by local men exchanging courtesies. For instance, a San Francisco man will come to Portland and lecture, and Portland men will exchange with San Francisco, Seattle, Spokane, Tacoma, Boise, Salt Lake, Denver and other cities. In other words, nearby cities and towns by exchanging courtesies can have public lectures given in all parts of the country two or three times a year and year after year with little cost for travel and no salary expense.

The local physicians can pay the advertising, hall rent, and traveling expenses if necessary of the lecturer, though I feel sure many volunteers will pay their own expenses.

To start with, a paid advertisement will be inserted in the daily papers, giving notice of a public meeting in a theatre to hear a lecture on homœopathy, and this advertisement would be signed by every homœopathic physician in the smaller cities and a committee in the larger cities. In this way it would carry weight, would not permit a few to profit at the expense of many, and would not be unprofessional in any way. During the lecture small folders sent out by the head publicity bureau together with the small folder of the local physicians giving the name and address and telephone of every physician, surgeon, and specialist in the city. There would be no difficulty in securing the co-operation of each physician in a financial way to such a plan as it would benefit all, and inform the public where homœopathic physicians could be secured.

Some established physicians might object to this plan from selfish motives, others from finicky ideas of professional ethics, but if any physician is honestly desirous of placing homœopathy before the world on the basis of its merit this is a practical, workable plan at a comparatively small cost.

I am pushing this plan and sending out the details of it to the leading men all over the country. It will go, or some plan closely resembling it. If we continue to follow our shilly-

shally methods or lack of methods, crawl into our holes, speak softly so not to offend our dear friends, the old school, and refuse to let the public know there are any homœopathic physicians, let us be consistent, order the makings of a first class funeral and awake and give homœopathy a decent burial.

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### THE HOMŒOPATHICITY OF VACCINES.

BY

JOHN BESSON, M. D., PORTLAND, OREGON.

(Read before the Oregon State Homœopathic Medical Society, Portland, Oregon, October 24, 1912.)

HUMANITY notoriously respects the opinion of the other fellow and is always off with the old and on with the new. We should, therefore, thank our management for the timely title of this Bureau, which in itself should insure attendance and attention to a marked degree.

Until the receipt of the program a few days since, I had looked forward to appearing under a poorly attended Materia Medica Bureau, whose papers are all too often respectfully tolerated with the hope that there may be little and short discussion.

It is suggested that I talk with you on the Homœopathicity of Vaccines, but I have refrained from presenting the name of my paper, thinking that a better one would be "Up-to-date Therapeutic Philosophy," while again nothing appeals to me but the title, "The Vindication of One Samuel Hahnemann." There was a scientist for you, and, like many, he labored before his time, yes, an hundred years before the world was ready or able to appreciate. You have heard that often enough and it is a rather vacuous statement, unless you analyze and compare the radical suggestions of the man of 1810 with the status of present-day therapy.

Then you will realize that while many of us have accepted his truths, trustingly followed his path and clinically reaped the benefits, only to-day has medicine the brain to comprehend the law of cure.

Hahnemann told the story of vital force and its vicissitudes—"Raise it to par and disease is no more," but his mere say so.

together with, "Try it and publish your failures to the world," was not proof sufficient for those who would not see. Wright dubbed "Vital Force" "Opsonic Index," went one step further than Hahnemann, by proving its variations, and to-day there is a proved reason for the activity of curative agents.

I will say to you here that other than the various electrical and mechanical therapeutic measures so highly perfected, and setting aside the germicidal method of cure, perfected possibly in the effort at one great sterilization of the patient as per Ehrlich, there is no means so potent as the use of bacterins. Too, here is the only real therapeutic point infringing on the homœopathic field.

The one controversy lies in the apparent efforts of nature in response to the stimulus offered, either by the properly selected drug or by the bacterin, and our ideas as to the *modus operandi* and intent of these efforts.

To clean up this question we must stop to a consideration of curative agents, their sources, the methods of their selection, and most simple, to-day, their mode of action.

As curative agents, we will consider only *antigens*.

An antigen is something, which, when placed or taken into the body, stimulates antibody formation of a particular variety.

The first requirement of any antigen is similarity. Mark that, please, as the bombshell in this paper; the point of points. The antigen must be the simillimum. Something which is nearest to that something causing the disease, and yet without being identical, is the prime requisite in determining a measure which will act curatively; act by aiding nature to cure; *i. e.*, one which will offer the necessary prod to nature, who then proceeds to raise her own opsonic index.

The bacterin is the typical antigen. First of all, what is a bacterin? A suspension of a number of killed bacteria. No longer a disease-producing agent, but now a remedy when properly selected, and, to cease generalizing, I will cite a specific instance in that of typhoid. Five hundred million dead typhoid bacilli forced into your system will not produce the fever. They will stimulate your organism to form typhoid antibodies, which fact has many times been demonstrated, beginning with the eighth day after inoculation.

According to Callison (who quotes from Major Russell and others), "corresponding to the time of development of antibodies in prophylactic vaccination, in the first eight or ten days



of an attack of typhoid there is a constant increase of temperature and aggravation of all symptoms. With the decline of the temperature to normal there is an increasing quantity of antibodies present in the blood, which may be demonstrated for long periods thereafter."

"From this correspondence in time between the clinical symptoms and the antibodies in an attack of typhoid fever, and the development of antibodies and immunity in prophylactic vaccination," Callison says, "it seems only proper to assume that recovery from typhoid and the development of immunity in prophylactic vaccination are brought about by a similar mechanism, and, that the prophylactic vaccination is an artificial, controlled process, which occurs naturally in an attack of the disease." He goes on to say, "Can this artificial, controlled procedure be applied in the treatment of typhoid?"

Did any among you ever before hear of an "artificial," possibly a drug produced, "controlled procedure," being applied in the treatment of morbid processes? If not, please consult your Organon. Long after the writing of that monumental work, opsonic indices have been raised by drugs homœopathically selected and the fact scientifically demonstrated at Ann Arbor, Boston and other places.

Do you know that eighty per cent. of Volunteers in the Spanish American War, and twenty per cent. of Regulars contracted typhoid (almost impossible of comprehension); that in the past three years there have been but twelve cases of typhoid in the Army, without one death, and under exposure, too, along the Texas border and in towns where many people died of the disease? And, just as certainly as the typhoid antigen confers immunity to the disease, may you grant the belladonna child immunity to a typical belladonna scarlet fever.

That, of course, has only been proved clinically, but could you desire more proof of the immunizing effect of a similar drug than the fact that some persons are so susceptible to rhus poisoning as to develop an attack year in and year out, irrespective of contact; and, that among 3,000 employes at a summer park in Philadelphia, through a period of ten years, there had not been one failure to establish immunity in all previously susceptible cases by two drops of the tincture of rhus tox in water three times daily?

This fact is attested by Dr. J. C. Attix, professor of chemistry, radiology, etc., at Temple University in Philadelphia, and

he, laboring on in his blissful ignorance, reports the circumstance, not suspecting for a moment that he was furnishing the proper antigen to those very rhus opsonin starving bodies in need of it.

However, like most of the tangible proofs of the law of cure, it comes to us as a gift from outside our ranks. Be quick to accept these proofs. Wright, VonBehring, Huchard, and the early immunity understanding men did not hesitate in using the term "homœopathic," and, in this progressive day, please to recall that we have always been the progressive party in the field of medical endeavor—the new school. Please continue new enough to be progressive and look with favor on anything holding forth a promise of immunity, remembering that, aside from the antitoxins which give antibodies already manufactured (and wisely, too, for there is no time for grinding out one's own antibodies in tetanus and diphtheria), nature does all the work in curing, the vaccine or the drug but offering the necessary prod.

Take with you, please, that "antigen," "indicated remedy," "vital force," "opsonic index," "immunity," and "homœopathy" are to be said in a breath, and reverently treasured in that private mental niche you have reserved for the memory of Hahnemann.

**ARGENTUM NITRICUM.**—The little people calling for this drug are withered, have a prematurely aged look, are flatulent, have much muco-purulent discharges and manifest a great desire for sweets, abnormally so. Purulent ophthalmia. Sudden and severe attacks of cholera infantum. Stools green, shreddy, bloody in children who have eaten too much sugar. face pale, old looking with much flatulent colic. Diarrhœa immediately after eating or drinking. Fluids go right through him. Patient is chilly yet feels smothered if wrapped up.

Argentum nitricum should not be given in trituration or tablet form if given lower than the sixth, as it is readily changed into the oxide. A solution is better preparation and liquid attenuations made therefrom. The sixth potency is a good preparation.

**Agaricus.**—Conditions characterized by jerking, twitching, trembling, and itching: spasmodic affections, chorea; paroxysms of yawning call for this remedy.

**Objective symptoms.**—Twitching of lids and facial muscles, skin is red and swollen; margin of lids red and agglutinate; inner angles of nose very red, herpes on lips; tongue tremulous; chilblains, angioneurotic œdema.—*Pacific Coast Journal of Homœopathy.*

## Transactions of the Homoeopathic Medical Society of the State of Pennsylvania.

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### BUREAU OF MATERIA MEDICA

WILLIAM A. SEIBERT, M. D., Chairman

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#### BELLADONNA IN DISEASES OF CHILDREN.

BY

C. S. RAUE, M. D., PHILADELPHIA.

At the suggestion of our chairman I have selected for my paper a study of belladonna in the diseases of children. To my mind there is no other remedy more useful and more frequently indicated in the general run of pediatric practice than belladonna. There are several other remedies, such as chamomilla and cina which have, so to speak, gained a reputation as children's remedies and while they are valuable still they are not nearly as frequently called for nor as generally useful as belladonna.

Children are relatively tolerant to belladonna but this fact does not appear to detract from its therapeutic efficiency.

Belladonna is a drug which is typically acute in its action and therefore well suited to affections that have a rapid onset and in which the initial symptoms are severe. The duration of these symptoms may be brief but they are striking and if the disease happens to be one of longer duration the clinical picture usually changes and indications for another remedy set in.

The physiological action of belladonna is chiefly upon the nervous system, namely a selective action on the brain cortex, stimulation of the cardiac, sympathetic and vasomotor nerves and a paralyzing effect upon the terminal fibres of the vagus. The pulse is quickened and a greatly increased general circulation results, together with rise of blood pressure. This accounts for the flushed face, throbbing carotids and erythematous eruption.

The brain is congested and headache, delirium and hallucinations result. The mucous membranes are dry and congested



and their secretions lessened. Dilatation of the pupils results from peripheral action upon the motor oculi and sympathetic and bears, therefore, no relation to the cerebral action of the drug.

A child in whom we find the above described state of circulation and cerebral disturbance is acutely ill and the nervous condition will vary from one of irritability and hyperæsthesia to wild delirium and deep coma. Convulsions may be associated or the presence of twitching of the muscles of the extremities, retraction of the head and gritting of the teeth will suggest their advent and cause great alarm to those who are watching over the child. There is no doubt that the administration of belladonna in the presence of such symptoms has time and again averted the occurrence of general convulsions.

One of the chief indications for belladonna is fever, and in my experience it is more frequently indicated in fever than aconite. The characteristic symptoms upon which we prescribe belladonna in the acute febrile disturbances of childhood are sudden onset without chilly sensations, such as belong to gelsemium, or a distinct chill as with aconite. A convulsion, however, may replace the chill when belladonna is indicated. The skin is hot and rather moist than dry; there may be sweating but the fever is not materially reduced thereby. The patient is drowsy or delirious; headache is usually present and it may be violent as shown by the knitted brow and the tendency to bury the head into the pillow. The face is flushed; the pupils dilated and there is photophobia; the pulse full and bounding. If we add to these symptoms vomiting, cough, or sore throat we have indeed a common picture which may suggest one of several different conditions. It may be impossible to say at once whether the child is developing tonsilitis, scarlet fever, diphtheria or broncho-pneumonia, but the administration of belladonna at this time will be beneficial no matter what the subsequent course of the illness may prove to be.

In acute bronchitis and capillary bronchitis belladonna is looked upon by some practitioners as specific and is prescribed in a routine fashion. We cannot gainsay the fact that belladonna undoubtedly covers the early symptoms of so many of these cases that there is justification for such routine practice.

The gastro-intestinal affections of infancy frequently call for

belladonna. In these conditions belladonna is more frequently indicated by the fever, toxemia and brain symptoms than by any special character of the stools.

In the early stages of whooping cough it is, in my experience, the most useful remedy and it is of great service in the neuroses of childhood and in chorea when fever and mental excitement are present.

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### BELLADONNA IN DISEASES OF THE FEMALE GENITALIA.

BY

Z. T. MILLER, M. D., PITTSBURGH.

EVERY woman who has reproductive apparatus; some few of them have yet; may thank homœopathy for belladonna. There can scarcely be an acute inflammatory process going on in that sphere without belladonna fitting in as the simillimum. Its active arterial congestion to the point of throbbing; its great sensitiveness to slight jar; its moist, pungent heat are quite sufficient for its exhibition. This state may be relieved by wet, cool applications, but it by no means follows that the ice bag is indicated. Unless my reasoning is at fault the ice bag is malpractice in localized inflammations. I remember, thirty-five or more years ago, hearing Professor DaCosta, of the University of Pennsylvania, warn against the ice bag. I cannot see how nature is going to bring about reparative reaction in a tissue that is devitalized by cold.

The feeling as if everything in the pelvis would fall out—worse sitting bent and in walking; better standing and sitting erect seems a little contradictory and yet I guess it can be harmonized. The symptoms are certainly characteristic. Feeling as if everything would fall out—better standing is an anomaly that is puzzling to the buggists. I recall no other remedy having it.

The fifth symptom in Hering's condensed brings belladonna strictly into line with the hæmorrhages of sub-mucous fibroids. "Profuse discharge of bright red blood, sometimes dark, clotted, and of bad smell; flow of blood between the periods." It is generally understood that fibroid proliferation in the womb is meat for the surgeon, and he generally gets it. Certainly, aside from pathology, or even with it I do not see why belladonna should not cure uterine fibroids.

The "clutching or clawing pains; stitches in the uterine re-

gion, parts sensitive, cannot bear least jar" may be the very earliest symptoms of a beginning fibroid and the remedy given at this stage of development might save future distress.

Its dryness of mucous membranes everywhere does not slight the vagina. There is great heat and dryness there.

There is no pathological mystery more profound than the ovarian cyst. That a container large enough to hold forty-seven pounds of fluid should grow out of a Graafian follicle is almost beyond belief. One would think that certain cells become possessed of devils to go off on a tangent like that. If cells are possessed of selective capacity sufficient for their own life what makes them so rapacious as to take on excessive growth even unto malignancy. One of the symptoms of belladonna is enlargement of the right ovary with stitching, throbbing pains that come and go suddenly. Might not belladonna nip an ovarian cyst in the bud?

There are other aberrations to which belladonna is homœopathic, but it will win its spurs if it nips cysts and tumors in embryo.

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Therefore, in conclusion, let us homœopaths not stop any longer at the bar that seems to halt our progress. Is the time not ripe for the separation of the tares from the wheat in our symptomatology of such well-proven remedies as belladonna? Continue to multiply provings, but authenticate the many symptoms we already have. Establish the genuine authorship, correct the definitions of the terms used to express the symptoms, corroborate them physiologically or pathologically, and verify them clinically. One remedy thus fully treated will mark the longest stride in this noble science of medicine and art of healing, and as yet is exclusively the property of our homœopathic wing of the profession.

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## THE VALUE OF BELLADONNA IN DISEASES OF THE STOMACH.

BY

H. M. EBERHARD, M. D., PHILADELPHIA.

FREQUENTLY the man who pays particular attention to diseases of the stomach will see a case with a fellow practitioner who says that in spite of belladonna being distinctly indicated it has failed to help his patient. He will further say that he



has tried it in the various dilutions with the same negative result. Now, gentlemen, when men who are skilled in the selection of homœopathic remedies meet this state of affairs so often, there must be a tangible cause. Let me cite a recent experience. I was called by a colleague to see a man who was suffering with violent diffuse pain in the epigastrium, temperature 101-102 degrees, pulse 140, respiration 40. Violent throbbing headache, occasional vomiting. Marked constipation. Careful inquiry revealed the fact that this attack was one of many. During the past year he had six similar seizures with each growing a little worse. During these paroxysms belladonna was always the indicated remedy, but for some reason it did not help. I elicited the statement that his physician told him to eat "light" food and be careful what he ate. This patient's light food during the seizure was ice cream, lemonade, orangeade, and cottage cheese. Here then, plus the fact that his bowels had not been moved for five days was the reason belladonna did not help this auto-intoxication, for such it was. Is it fair to expect any remedy to show its true therapeutic worth when an exciting cause is not removed? How *could* this cited case improve on the diet permitted during the seizure! With a properly selected diet, the intestinal canal made to act, etc., belladonna would have surely helped this patient more quickly. Another similar instance along the same lines is, when belladonna is indicated in an acute gastric ulcer and the patient is allowed to take a diet which excites the disease, is it reasonable to expect any remedy to act? Let me emphasize that belladonna given when indicated and the exciting cause not removed, is just as reasonable therapy as the treatment of a fractured limb without a splint. Belladonna acts best in *acute* gastric disturbances, where there is inflammation of the mucosa. This inflammation may involve the mucosa alone or extend through all the structures to the peritoneum. Usually a moderate amount of fever exists, rapid bounding pulse, cerebral excitement, throbbing headache, hot, moist and steaming skin. The epigastrium is diffusely tender and often distended, with vomiting of a sour substance. Crampy pains in epigastrium relieved temporarily by eating or vomiting are symptoms of this drug. Clinically, we have a picture of acute gastritis, acute gastroenteric auto-intoxication or the beginning of some organic stomach lesion such as ulcer. Belladonna from the tincture to the

third decimal dilution and even higher will act admirably if the exciting cause is removed. By far my best results obtained by this remedy have been in cases where for some reason a hypersecretion, hypermotility or hyperesthesia of the stomach existed. These conditions, as you are well aware, occur in acute gastric ulcer, hyperchlorhydria and from neurasthenia, etc. Take acute gastric ulcer, for instance, where a gastric analysis reveals a marked hypersecretion, where the patient complains of violent pain one to four hours after meals, relieved by eating or vomiting, belladonna or its alkaloid atropin will at times give such relief in conjunction with a suitable diet as to be almost astounding. In order to limit the secretion or suppress the flow of gastric juice, it is necessary to give the drug in sufficient dose. Two to three drops of the homœopathic tincture—ten drops of the official U. S. P. tincture—one eighth to one-sixth grain of the U. S. P. extract or one one-hundredth of a grain of atropine sulphate given twenty minutes before meals twice or three times daily is ample to control or suppress the gastric secretion in an adult. I know of no remedy in acute gastric ulcer that will stop auto-digestion of the gastric mucosa and give that membrane a chance to heal, so valuable as belladonna.

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## BUREAU OF SANITARY SCIENCE

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### THE EDUCATION OF THE PUBLIC IN SANITATION.

BY

MALACHI W. SLOAN, M. D., PHILADELPHIA.

In presenting this subject for your consideration I am giving the broadest possible meaning to sanitation. It is a part of the science of hygiene, and consists of rules of personal and public cleanliness to promote health and prevent disease. It is also a part of preventive medicine.

The public is very far behind advanced medical thought and is therefore not deriving the benefit it should from the science of medicine. There is enough accumulated knowledge in the science of medicine to-day at once to stamp out all infectious diseases, and greatly to reduce those that are not infectious.

Many of the chronic incurable diseases are the results of the avoidable infections.

While we possess the information to eliminate many diseases, it is not practical to do so, because there are many obstacles in the way, which must be removed before the human race can enjoy the benefit of perfect sanitation. To remove these obstacles two important factors are necessary: First, the medical profession must appreciate its responsibility in this matter more than it does and map out a plan of action. Secondly, the public must have the information necessary to get results and the information must be given by the medical profession. Of course progress is being made along this line, and compared with the past it is rapid, but it is slow in comparison with what might be accomplished. At the present rate of speed the end of the next century will enjoy what we might have now, if our energies were directed properly.

To be sure, we meet a number of persons with a certain knowledge of medical matters; still the larger public is ignorant of matters of vital importance to the preservation of health. In certain instances this kind of knowledge is detrimental and is often the cause of useless apprehension. An old saying, "A little knowledge is a dangerous thing," certainly applies here. It is therefore essential to give only what information is necessary. "An ounce of prevention is worth a pound of cure," is another old saw, and also applies well to our subject. We know how often the pound of cure is given.

Every doctor is a health officer and should consider himself as such, never missing an opportunity of giving individual instruction to his patients; the profession must place itself in a position in which the public will have absolute confidence in its actions. I believe the profession is very much misunderstood, and does not enjoy the confidence it deserves. To educate the public we shall be obliged to educate ourselves, so that we will now not only consider what the public should know, but our own relation towards the prevention of disease.

The simplest facts regarding the transmission of disease never reach the public, but a new cure for cancer or a specific for consumption gets display type in the newspapers. A simple sanitary rule meets with strenuous opposition. It is only a few years since it was proposed to use individual communion cups, and now, as far as I am informed, this is universal. Many persons objected to drinking out of a cup that others used,



even when they were not aware of the possibility of disease being transmitted in this way, their reasons being simply those of personal cleanliness. Strange as it may seem, the individual communion cup was objected to by many. These same protestors are always with us to hinder progress, and stranger still, sometimes we find one of these protestors with a diploma to practice medicine.

Hahnemann said: "The physician's highest and only calling is to restore health to the sick, which is called Healing." The cause of disease was known in Hahnemann's time, but not in the same way that we know it now. To-day physicians, especially those in general practice, should be sanitarians, and when we combine sanitarian and physician, then healing is not the only duty of the physician: it is also his duty to prevent disease. The physician may cure the patient without the patient's assistance, but the sanitarian is of very little use without the co-operation of the public. When medicine was in that stage in which we did not know how to prevent disease, it was only necessary to try to cure, and the physician did his full duty when he tried to restore the patient to health; but to-day the physician only performs his full duty when he tries to prevent disease. If his patient becomes ill, which might have been avoided by the giving of timely advice, but which was not done, then he has been negligent. The profession is negligent to-day if it does not use with all its power the knowledge it possesses to prevent disease in general.

As I have said, the public must co-operate; to co-operate it must be educated, and to educate the public each physician must do his part as an individual instructor and the profession must do its part through the power of organization. The successful physician enjoys the confidence of his patients and his word has great weight, but I cannot see that this confidence is extended to the profession. By some means we must gain this confidence, so that we can control all matters pertaining to health. The very first thing to do to gain this confidence is to make a united effort to agree and not to disagree as we usually do. Instead of being jealous of each other, we must be jealous of our profession. We must not tolerate useless attacks on it. Secondly, nothing will go so far to gain the confidence we desire as a united profession. It is certainly time for the profession to get together on therapeutic differences. Not one of the three systems covers the whole field, and I believe

the large majority of physicians agree to this. We might lose something by the union, but we would gain more, and irrespective of gain and loss, the union is necessary for the general good.

One of the difficulties we constantly meet in our attempts to improve conditions, is the suspicion of the public of ulterior motives on our part. It is difficult for a business man to get our view. His constant thought is to increase business and profits, and while he would probably not accuse us of doing anything to cause an epidemic, he does accuse us of a desire to dominate matters which are allied to the profession.

Not so long ago the medical man had to deal with the individual quack. Quacks came and went. Their efforts were directed towards the gullible individual, who eventually became wiser. The conscientious physician always wins out against the quack. We still have this quack; but besides the individual quack there is a new danger to the community with which the individual physician cannot cope; and that is organized quackery. To fight this a solid organization is needed on our part. Patent medicine concerns are organized and prepared to fight any legislative act that would put them out of business. They hinder progress in medicine and if they could they would willingly undo all the good that the science of medicine has accomplished. One school goes so far as to deny the existence of disease altogether, constantly breaks our health laws, and is never successfully prosecuted. If a physician of this school has a death, it is always argued in extenuation, that even regular physicians lose patients. This seems to be a very convincing argument to the jury and even to the judge, and as they do not care to interfere with religious beliefs, the unlicensed and irregular practitioner is given his or her freedom. These irregular practitioners are, as a rule, clever enough to save themselves trouble by calling a doctor, and the doctor kindly signs the death certificate. Under such circumstances, the doctor does himself an injustice, but the greater injustice is to the medical profession. Furthermore, those that have called him in to escape trouble, do not respect him for his act.

These are a few of the matters in which the public should be educated by the medical societies through the medium of the press. Every state and county society should have its publicity bureau, and articles of common, everyday interest should be

published in the press and distributed in pamphlet form. The space used in the press should be bought. I do not wish to be misunderstood here and have it thought that I desire to get the medical profession into wordy controversies, because such is not the case. The public does not know the importance of seeking medical advice early. They do not know one half of the good things in medicine, and the simple everyday victories of medicine should be published. In this same manner the public should be informed of certain nuisances and the medical profession, by a committee appointed from our societies, should devise means of correction, which should be published; and this publicity kept up until results are obtained. It is time for a united profession to take charge of all matters directly bearing upon the health of human beings.

Finally, the doctor in general practice that insists upon his patients sending for him at once in all cases of sickness, and also takes the trouble to give advice on prevention of diseases, will sign fewer death certificates than the one who takes the opposite course.

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#### THE RELATION OF FOOD TO CERTAIN BODILY AILMENTS.

BY

R. E. TOMLIN, M. D., PHILADELPHIA.

NATURE's inviolable laws teach us that the integrity of the mind and body is dependent upon the sum total of what enters them, and the inexorable penalties that result from violations of her laws.

Some one has said that words are creatures of chance, subject to jeopardy from all the winds that blow, and that in writing one is only increasing the hazard of misunderstanding; yet if nothing is ventured, nothing is gained either in presentation of view or in frank discussion.

Herbert Spencer says: "In proportion as we love truth more and victory less, we shall become anxious to know what it is that leads our opponents to think as they do. We shall begin to suspect that the pertinacity of belief exhibited by them must result from a perception of something which we have not perceived. And we shall aim to supplement the portion of truth we have found with the portion found by them."



That's splendid. For many centuries the problem of feeding was a not over-important one. Of recent years it has become a mighty factor, so that the lay mind is almost as familiar with the subject as the average professional mind. So very conspicuous has this become that all manufacturers of special foods have an abundance of suggestions concerning their particular products, both in health and diseased conditions. Consequently one of the most frequent questions asked the doctor to-day is, What can I eat? or, What shall I give the patient to eat and drink? Billings and Salisbury say that "dietetics take the first rank." By that they mean sensible eating and drinking when necessary. Here are a few well known laws:

1. The human body must accumulate disease before disease can exist.

2. The germs of disease must enter the soil in the body and be there developed before disease can attack the body.

3. The human body is dependent upon food, with its all-inclusive potentiality, for its sustenance and continued existence.

4. What food is not digested passes out through the intestines and other organs. What food is digested, but not assimilated, dies in the blood and flesh. It has been said that "health cannot be maintained, nor disease overcome by an appeal to 'reason,' or to a course of treatment that is based upon 'good sense.' " The doctor who seeks to effect a cure by outlining such a course will fail in ninety-eight per cent. of his cases, because it is not either desirable or popular. It is assumed that the human palate was given for the purpose of demanding satisfaction. It can not or will not be dieted; if it did the result might be good health. Freedom is demanded by humanity in all things, and in none more than that under consideration.

Prof. R. E. Thompson, in his lecture on Ethics states: Ethics is the science of right feeling, and right thought, leading to right action. Unreflecting human life was a body of customary usages until Socrates set the Athenians, and after them, the civilized world to asking why they felt obliged to follow this or that custom, and thus began the science of ethics.

Although man has been eating and drinking for almost unknown centuries before Socrates lived, the science of dietetics can hardly be said to be exact even in the twentieth century. Dr. Perry says: The world at large is just beginning to appreciate the enormous importance of the nervous system and the far-reaching effect upon the human economy of any interference

with its nutrition and functions. Voluntarily or involuntarily every beat of the heart, every movement of the hands is governed by the nerves, and without their controlling influence the most perfect human organism is a mere collection of useless organs. The maintenance of nerve force and the power of co-ordination and the instant transmission of brain impulses is vital to energy, health and even life itself. When the nervous system becomes deranged or diseased a train of consequences ensues which is frequently not manifested in the nerves themselves, but in the organs which they govern and control. Nervous headache, nervous gastralgia, liver torpidity, intestinal lesions, etc., etc., are plain examples. No organ or part of the body is excepted.

Professor Dubois says: "Man is the only animal that does not know how to live." "Man alone loses his way, falls into the same mistakes after having been punished a hundred times—and when he suffers he accuses his unlucky star, or reproaches someone else for his unhappiness."

To be masters of others, we must first master self, needs to be inculcated in the mind of the physician almost as much as the layman.

Professor Payot says: "Our happiness depends on the education of our wills; but it is not only our happiness which depends upon the degree of power which we acquire over self, but still further, our highest intellectual culture. It is by cultivating the will that men of genius are made for all those higher qualities which are attributed to the intelligence are in reality qualities of energy and of constancy of will."

Prof. R. H. Chittenden, of Yale University, says, that after all the laboratory factors are considered, there are still unsolved problems that are known as accessory factors in the digestion and assimilation of food, and that the full solution of the food question in health, much less in disease, is not known, and will not be for years to come; in other words, the laboratory and the clinic are not yet in accord; we cannot dispense with either, each must support and agree with the other sooner or later.

Professor Ramsey, of Aberdeen University, the world's greatest physicist and chemist, recently said (1912) that the works on chemistry will have to be re-written, because of the advances in chemistry and physics in recent months. He also says it is the recently discovered accessory factors that will revolutionize the manner of thinking and mode of living.

Perhaps you are familiar with the theories of Prof. Elie Metchnikoff and others concerning the problems of living and longevity. What he thinks of the character of the food eaten, the diseases that follow in the wake of the ingestion of large amounts of nitrogenous foods, and how by eating certain combinations of food life may be indefinitely prolonged. Other eminent scientists view the question from other points and maintain they can demonstrate good health and long life from combinations of food, etc. that the aged and eminent professor condemns.

A writer in the *Journal of the American Medical Association* has recently suggested that experiments having to do with special diets should be continued for long periods of time in order to be regarded as demonstrative. Herbert Spencer used to say that every widespread belief has back of it at least a germ of truth. Therefore the advocates of either meat or vegetarian diet will do well to ponder all the experiments and facts deduced therefrom before becoming so dogmatic and final in their conclusions. We are all familiar with the fact that the mood of a person at mealtime is a determining factor of no small importance.

The sense of smell is a potent factor in stimulating the flow of gastric juice; and meat broths are highly stimulating to the gastric juice, hence are of value at the beginning of a meal.

Dr. Levenson's explanation of the "course dinner" is at least interesting to us. The dessert course is composed largely of carbohydrate preparations, pastry, sweets, fruit flavors and cream. Foods of this order, as is well known, are not primarily digested by the gastric juice, but are acted on by the salivary ferment known as amylase. This ferment is incorporated with the food in the mouth, and will continue to act until it is neutralized by the gastric juice. Recent studies show that the food last ingested occupies a central position in the stomach for some time, and that only the peripheral portions are actively in contact with the gastric juice. Thus the carbohydrates that make up the dessert are so located as to be acted on advantageously and for a prolonged period by the salivary ferments incorporated with them; whereas, had the same foods been ingested early in the meal they would have been brought at once in contact with the periphery of the stomach, and their digestive changes arrested. Wherefore the intricate mechanism of digestion is better understood, etc., etc.



The word Electricity, used later on in this paper, is used in its most recent popular sense, and indicates an enormous fund of vitality. It has no relation whatever to mechanical or commercial electricity. It is a question whether the nervous currents of the human body are electrical in a physical sense, that is the mechanical force in physics. The currents spring from the ganglionic cells which are undoubtedly storage batteries; they run along the nerves, and they discharge their currents upon the muscles which alternately contract and relax and perform the work assigned them by the brain. Sir Wm. Ramsey, the brilliant scientist, claims to have discovered the electron in the early part of 1912, and says he has proved that electricity is a substance, as he has repeatedly demonstrated its material properties. No scientist has been bold enough to claim this much before, although many have believed it. Foremost among them is Col. G. W. Warder, of New York, who lectured and wrote upon it in 1898 to 1904.

Colonel Warder, an eminent scientist, has said: "I contend that man's body is an electric machine or organism, and electricity is its vital force and governing power, and all sickness is caused by the electrical derangement of the bodily organism. Electricity is the force which organized the body machine, which runs it, and whose loss or deficiency cripples and finally destroys it." He further states: "Sickness is the impairment of some of the parts or functions of the body by reason of its failure to get its necessary and normal supply of electrical energy. This may be caused by an injury to some of its parts, or by lack of proper air, food and nutrition containing the electric properties required. For air is an electric element from the life-giving sun, and vegetable food is the embalmed rays of the sun, and animal food is vegetable food embalmed in animal organism, and brought one step nearer to electrical digestion, and both air and food are necessary to supply the vital electricity to the living organism. While man can live without food for forty days, he cannot live without air four minutes. The great force and power which run the human machine is the vitalizing air we breathe, the electric atmosphere in which 'we live, move and have our being.' It is as much a substance as the water in which the fish swim, though it is transparent to light, while water is only partially so."

Flammarion says three fourths of a man's life energy and

nourishment comes from the air. Nicola Tesla affirmed, the time may come when man may learn to live on air alone, as do some kinds of vegetable and animal organisms. Man in time may learn to so mix the elements of that atmosphere to supply the needs of the body, that he may by breathing it into his lungs obtain all the essential elements to preserve life. The lungs take in pure electricity from the air, while the stomach takes in compound electric elements, vegetable and animal, and converts them by the electric process of digestion and assimilation into blood and bone, nerves and tissues, and the two functions give vitality and growth to the whole body.

The electric and controlling centre of the bodily machine is the electric dynamo of the brain, to which is attached the spinal column with its nerve branches reaching out to all parts of the body, along which, as on connecting wires, the brain telegraphs its wish and will, and governs the whole organism. Here the mind or soul dominates the brain, and the brain dominates and controls the body. Through all the vicissitudes of life, until the final dissolution of the body, the telegrams from the brain running along the wires of the nerves control the muscles, the movements and all the varied utilities of the body. Consumption is a disease caused by a failure of the lungs to draw sufficient electricity from the air to supply the normal needs of the body, this failure permits the tubercular bacilli, and the streptococcus and other germs to invade and destroy. For lack of this electric energy the whole system becomes enfeebled and finally dissolved. Indigestion is a failure of the stomach and related organs to supply the electric energy to digest and assimilate the food. All sickness, aches and pains are nature crying out for the energy necessary for her to fulfill her natural offices and functions, and this because the food having the potential qualifications is not eaten either in the proper combinations, proper amount, or right time, and under conditions absolutely necessary for normal living.

Dr. Jacques Loeb, of the Chicago University, announced on February 22d, 1903, that he believed that muscular and nervous diseases, such as chorea, paralysis agitans, locomotor ataxia, insomnia, neurasthenia, psychasthenia, et al., can be materially benefited if not cured by the administration of foods and remedies containing the calcium salts because of their electrical effects. He maintains that the presence of calcium salts

in the muscular tissues prevents all forms of twitching and nervousness.

This paper might be said to be an amplification of a paper read before this society during the session of 1908 and you are advised to refer to it. Appendicitis is becoming more frequent every year; it cannot be traced back indefinitely; nor can it be merged into some other intestinal disease that may have existed many generations ago. It is the legitimate offspring of wrong eating and drinking. Again, permit me to state that:

1. There never was a time when food adulterations of so grave a nature and so general a practice as is resorted to in this day.

2. There never was a time when so many chemicals were used.

3. There never was a time when so much meat was eaten, and at so many meals; formerly it was only at dinner, now at nearly every meal.

4. There never was a time when so many entrails and viscera of animals were eaten.

Appendicitis as a disease of a puzzling nature is being studied more than any other malady to-day. Experts have come to various conclusions as to the cause; but the consensus of the best opinion is in the causes above narrated. The writer cannot go into this more fully at this time.

For a moment, look at apoplexy. This is said to be due to a weakening of the walls of the vessels, whereby they are unable to endure the pressure of the heart's pumping action. This weakening has a double cause; first, a poisonous state of the blood, generally due to a morbid condition of the kidneys; second, the deficiency of nutrition in the blood. In other words, the blood is not rich enough in nutritive matter to build strong walls through which the fluid may be forced. Professor Edgerly, an eminent authority, says: "From the study of many thousands of cases of apoplectic tendencies we have come to the conclusion that the origin of the malady is in carbon poisoning. It is the presence of too much carbon in the body, or else of a deterioration of the carbon that is admitted into the system daily. Alcohol may or may not be one of the principal causes of carbon poisoning; it is merely pure carbon in itself, but in many instances in a form that has been perverted. The use of any form of alcohol by persons who are liable to an attack of apoplexy is regarded as most dangerous. The rule



should be to let it severely alone, whether taken in the form of beer, cider, wines or liquors of any kind. This is also true of all patent medicines of a liquid nature. Never allow any liquid to enter the stomach unless you know what it is. Whether you use alcohol in any form or amount, it is possible to set up carbon poisoning by eating or drinking too much of this kind of food. Sugar is almost pure carbon; but it becomes a new form of this element when it is passed into the blood. If you were to eat nothing but sugar you would soon bring on kidney trouble from carbon poisoning, much more quickly from other carbon compounds. It is the desire for carbon that rules most people; the excess produces the danger. There is another kind of danger that does not depend solely on excess; it is the imperfect disposal of the carbon after it enters the system. Digestion, use, absorption, and the final burning up or consumption of the fuel, for that is the only office of the carbon, must be complete at each stage, or carbon poisoning will result. To secure control of these conditions it is necessary to consume less of this fuel. That is take no alcohol in any form; take less of the sweet things, avoiding candies, cakes, sugars, and all rich cooking. Carbon is present in all grains, all flour, all sugars and sweets, all fats, all oils, and in nearly all else that is eaten in some proportion. There are some foods known as the carbon class, and it is these that are to be used in lesser degrees and amounts until the apoplectic tendencies disappear altogether, and to discontinue their use as a prophylactic measure in all these conditions or closely related ones.

It is readily seen from even a hasty review of the above statements that practically every disease has a prominent causative factor in the problem of feeding. An eminent physician recently said: "There are more than a million graves that have been filled by the frying pan in our own land." An expert authority on tuberculosis said: "Nothing breaks up the blood so fast as pastry and fried food." If to have a sound mind there must be a sound body; and if a sound body is dependent upon the food eaten, how imperative it is that we take heed what we eat and drink.

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**BUREAU OF GYNECOLOGY****W. A. STEWART, M. D., Chairman****INFECTION OF THE FALLOPIAN TUBES.**

BY

**J. C. CALHOUN, M. D., PITTSBURGH.**

THE most important among the diseases of the Fallopian tubes are the inflammatory diseases, which are all due to infection. The structures are invaded by micro-organisms from without, usually from the uterine cavity, more rarely the abdominal cavity; these lodge in the folds of the mucous membrane and produce a reaction which extends to the muscularis and the serous coat.

The inflammation consists in, first, thickening of the mucous membrane, frequently desquamation of the epithelium and enlargement of the tube.

The longitudinal folds of the mucous membrane becoming abraded and lying in apposition, frequently become adherent, forming what appears to be cysts. With the extension of the inflammation to the mucous membrane, increased secretion follows, portions of which are discharged into the peritoneal cavity, and cause inflammatory conditions, which cause plastic material to be thrown out, and close up the end of the tube with inflammation and thickening of the mucous membrane, it becomes contracted and leads to retraction of the fimbriae, or by the contraction of the muscular layer, it pushes the peritoneum over the abdominal orifice, which becomes agglutinated and closes the opening. Occasionally one or more fimbriae may protrude, thus leaving a track by which fluid subsequently may escape into the peritoneal cavity.

With the closure of the tube the increase of contents causes an obtuse ended tumor which gradually fills, forming occasionally a pear-shaped mass, or where its walls in places are constricted by an increased amount of fibrous tissue, a sausage-shaped tumor is formed.

Palpation of the normal tube is very difficult, and possible only under favorable conditions of the abdominal walls. Diseased tubes, owing to the thickening of their walls are quite

easy to feel. If the tube is very near the anterior pelvic wall, it may be difficult to bring the fingers together at that point, but if the uterus be elevated with the internal hand, thus bringing the uterus nearer the abdominal wall, it will be felt with the external hand as a transverse cord immediately underneath the abdominal wall. In searching for the tube the hands must be kept near the cornu of the uterus because the tubes are hardest at that point, whereas near the abdominal extremity the tube is softer and its shape more indefinite.

The palpatory findings in salpingitis vary, depending upon whether the process is quite acute, or secondary changes resulting from inflammation are present. In acute conditions owing to the greater tenderness of the tube and the peritoneal involvement, it is usually impossible to feel the tube itself, and the examiner must be content with localized tenderness in the tubal region, hence the diagnosis at this stage is usually uncertain. After a certain interval the tubes themselves can be felt and the inflammatory changes can be demonstrated by palpation. The changes vary according to the intensity of the inflammatory reaction.

In the mildest forms of catarrhal salpingitis the tube is but little thickened, often merely a little harder than a normal tube, and somewhat painful on pressure. In chronic cases pain occurring only at the instant when the tube is engaged between the palpatory fingers, is the only demonstrable sign. The greater the inflammatory reaction in the wall, the thicker and harder will be the tube. The ovary may be found isolated in the arch formed by the tube or close to the abdominal extremity.

In purulent salpingitis the objective changes are much more pronounced and the diagnosis is accordingly much easier. The tube, which is often as thick as the finger, is readily identified by its arching and slightly tortuous course. It is always easiest to feel the uterine portion of the tube, which begins at the cornu, because it is broad and thick and occasionally contains a few nodules; while the lateral portion being filled with secretions and adherent to the pelvic wall and the ovary, is much less distinctly felt. The consistency of the tube is firm, and tenderness is rarely wanting, but depends in the main on the character of the accompanying inflammation.

The diagnosis of tubal disease is rendered much more difficult by certain displacements of the uterus. In retroposition,



for example, the fundus and tubes are placed far backward and it is very difficult to differentiate them. Examination under anaesthesia is often required. In retroversion and retroflexion it is almost impossible to feel every portion of the tube, the uterine portion, which is diagnostically most important, can be felt only by forcibly elevating the posterior vaginal vault. On the other hand, the club-shaped extremity, which is directed forward, can often be felt quite easily. It may be possible by means of a rectal examination to recognize the tubal disease when the uterus is in retroflexion.

If the swelling of the tube is at all distinct, it is hardly possible to mistake the diagnosis of salpingitis. The normal ovary must not be mistaken for the abdominal extremity of the thickened tube. If the ovary is spindle-shaped and gradually merges with the ovarian ligament, it may resemble a tube very closely, but as the latter is inserted higher up at the fundus, while the ovarian ligament is much lower down, the point of insertion can be determined by careful examination of the lateral aspect of the uterus, or the uterine portion of the tube, in which the changes are most distinct in every form of tubal disease, may be investigated.

Parametritic and perimatritic adhesions rarely give rise to errors, because diseased tubes are thicker and more round than adhesions and because the latter are usually multiple and do not present the characteristic course of the Fallopian tubes. Accumulations of scybala in the sigmoid flexure, and sometimes even the empty gut may be mistaken for a thickened tube on the left side because the scybala simulate tortuosity and may occupy the situation of the tube. The sigmoid flexure, however, owing to the length of its mesentery is always more movable than the tube; it is sometimes placed in front of the uterus, and the scybala, unless they are too hard, can be compressed and are not painful.

Finally, the diagnosis can be assured by repeated examinations, particularly after laxatives have been given.

After the diagnosis of inflammatory tubal disease has been established, the etiology remains to be determined. Aside from the scientific interest, this question is important to the practitioner because the prognosis and treatment are materially influenced by the variety of micro-organisms, which has produced infection and by the specific tissue reaction.

Of the micro-organisms that are capable of producing tubal

disease the following have been found in the tube: gonococci, tubercle bacilli, streptococci, staphylococci, pneumococci and actinomyces.

Gonorrhea is by far the most frequent cause, even when it is remembered that gonococci are rapidly destroyed and that the great majority of cases in which the pus is reported as sterile are also gonorrheal.

Gonorrhea, tuberculosis and septic salpingitis are the only conditions that have any practical importance. In most cases the differential diagnosis between these three varieties is possible and is based first on the objective examination and, second, on the symptoms and the course of the disease. If these means fail, a bacteriological examination of the pus obtained by aspiration may be made.

Since gonorrheal salpingitis is by far the most frequent form of tubal inflammation, being present in from 80 per cent. to 85 per cent. or more, of all cases, it may be assured unless there are definite reasons for suspecting some other form of infection. Upon examination the tubes show nothing characteristic to distinguish this from the septic form, while tuberculosis can often be differentiated from either. If extensive parametric exudates are found underneath the tube, the condition is probably not gonorrheal. Small exudates may be present with gonorrheal pus tubes. If gonorrhea is positively demonstrated in the lower portion of the genitalia, particularly the uterus, tubal disease may be attributed to the same cause with a fair degree of probability, but if no signs of gonorrhea are found in the uterus, gonorrheal pyosalpinx must not be excluded on that account, as the disease tends to subside in the mucous membrane and infection in the uterus may be present without producing any symptoms. If the salpingitis develops after menstruation and especially a short time after marriage, the condition is very probably gonorrheal. Gonorrhea in the husband is also an important diagnostic point.

The septic form, which is due to infection with staphylococci and streptococci and may be estimated as representing 5 per cent. to 10 per cent. of all cases, is difficult to diagnose on account of the paucity of the physical signs, among which I may mention the presence of extensive parametric exudates, associated with protracted fever that can only be referred to the tubes. As a rule fever of a few days' duration occurs only at the beginning of a gonorrheal infection or recurs with sub-

sequent exacerbations, while in septic salpingitis, possibly owing to the constant production and absorption of fresh toxins, the fever may continue for months and may return again and again at the menstrual period. But little information is obtained from the history. The fact that the tubal disease followed infection during the puerperium is not diagnostic because gonorrhea very frequently appears in the tube during the puerperium. The same thing applies to salpingitis following curettage and sounding of the uterus, because these manipulations also permit of the gonorrheal process extending to the tubes.

Tuberculous salpingitis is so well characterized by its symptoms, course and physical signs that diagnosis is usually possible. The condition of the tubes themselves is not particularly characteristic. As tuberculosis is accompanied by marked infiltration of the walls and suppuration, if it occurs at all in the typical form, develops late, the tubes are found very much infiltrated, and somewhat rough or nodular, if infantile tortuosities are also present. If the infection is derived from the uterus, the nodes are most distinct in the uterine extremity. If pyosalpinx develops, these signs are not present. As tuberculosis is either derived from the peritoneum or extends to that membrane, signs of peritoneal disease in the form of ascites or peritoneal nodules are almost regularly present. The combination of ascites and swelling of the tubes is an almost positive sign of tuberculosis; for, although ascites also results quite frequently from neoplasms of the tube, that condition is quite rare. Signs of tuberculosis in the genitalia, such as tuberculous ulcers or tuberculous endometritis confirm the diagnosis. The presence of tuberculosis in other organs renders the diagnosis very probable, hence, the lungs, the bones, the joints and intestines and skin must also be investigated. Doubtful cases may be cleaned up by resorting to the tuberculine reaction.

Leukocytosis affords a valuable means of recognizing the most important contents of the tubal tumor, namely, pus.

It has been shown by Dutzman, Pankow and others, who have made systematic leukocyte counts and confirmed the diagnostic significance of the sign by the results of operations, that a distinct leukocytosis is almost always present in suppurative salpingitis. On the other hand, the actual number of leukocytes is smaller than in the case of recent abscesses and, as a rule, does not exceed nor fall much below 15,000. The rea-



son probably is that after the acute process has run its course, leukocytosis slowly subsides on account of the death of the micro-organisms, although pus still persists. Hence, a comparatively low leukocytosis demands consideration in the diagnosis. According to Pankow's results, a persistent leukocytosis of 15,000, provided of course every other cause has been excluded, indicates pus, but a count of less than 10,000 does not exclude pus presence. The low figures may be in part also attributable to gonorrhea, which on account of its local character, produce a considerably lower leukocytosis. In ten cases of tuberculosis pyosalpinx examined by Dutzman and Pankow, leukocytosis was constantly absent, while in streptococcal infection large numbers of leukocytes were always found.

On the strength of these observations, leukocytosis may be utilized with certain reservations for the diagnosis of pus in tubal disease; indeed, it almost seems to afford a means of differentiating the various forms of pyosalpinx.

#### TREATMENT.

The treatment is either surgical or non-surgical.

During the early part of the disease it is best to use non-surgical means.

First. Because many infections recover completely under this form of treatment and later go through normal pregnancies provided re-infection is avoided.

Second. Because surgical treatment is exceedingly dangerous during the early period of the disease, while it is safer later on.

Third. Because the patient is not exposed to any risk by postponement of operation, provided the internal treatment is carried out properly, and rest in bed is insisted upon.

The non-surgical treatment is rest in bed, light yet nourishing diet, hot vaginal douches and the indicated remedy.

The douches should be given as hot as can be borne, at least a gallon at a time every four to six hours. They are a source of comfort and benefit to the patient.

The following remedies may be called for: Aconite, belladonna, apis mel., arsenicum, colocyth, cantharis, mercurius cor., calcaria carb., lachesis, sulphur and many others.

Although a large majority of cases in which there is but a single infection of the Fallopian tubes will recover fully or to

such an extent that it is impossible to determine the presence of any pathological condition by physical examination, there will always be many who have either had repeated infections or have not recovered fully from a single infection, and these cases can be relieved permanently only by a surgical operation.

The operative treatment must be planned so that none of the clean portions of the abdominal cavity become infected during operation, so that all of the disease is removed, and so there will be no serious secondary conditions developed as the result of the operation.

To prevent the infection of portions of the peritoneal cavity not involved, it is wise to make the abdominal incision of such length that the surgeon may make the necessary manipulations in sight.

The operation can be greatly facilitated by placing the patient in the Trendelenburg position, by elevating the foot of the table so that the patient's body rests at an angle of about forty degrees. This causes the intestines to withdraw into the upper portion of the peritoneal cavity, or if they do not take this position by their own weight the object may be accomplished by pushing the intestines upwards by means of large moist, sterile gauze compress. The intestines should be carefully tamponed away from the seat of the operation as thus they will not be exposed to infection during the operation, nor the irritating influence of the air.

The entire operation can now be done without manipulating anything outside of the pelvis and that portion of the peritoneal cavity is the least sensitive and its manipulation is accompanied by the slightest amount of shock. This is a fact of very great importance, and if borne in mind the patient's suffering may be reduced and her chances of recovery much improved. The further steps of the operation will depend upon the extent of the infection and upon the parts involved, as well as upon the number and firmness of adhesions.

If the Fallopian tubes alone are concerned the operation is the same as for removal of ovarian cysts. The broad ligaments will be ligated below the mass and a second ligature placed around the Fallopian tube, near the uterus, and the mass cut away, leaving sufficient amount of tissue beyond the ligature to prevent slipping. It is well to place a pair of forceps upon the Fallopian tube beyond the point at which this is cut away in order to prevent any leakage from the cut.

If the adhesions are extensive it is often much easier to place two pairs of forceps upon the Fallopian tube at its point of entrance into the uterus. The forceps should be placed parallel to each other, then the tube cut away between these, which opens the space between the upper and lower fold of the broad ligament. By applying the forceps successively upon the broad ligament from within outward, and cutting between, it is usually possible to enucleate the pus tube without the dangers of rupturing it. In many cases the uterus itself seems so thoroughly infected that it may be best to remove it, together with the tubes and ovaries.

It is particularly important to exercise care in inspecting the surfaces of the small intestines which have been adherent to the ovaries or tubes, or to the infected uterus, as in loosening these adhesions it sometimes happens that a loop of intestine is perforated, and unless such perforation is carefully closed and the surface covered with peritoneum a fecal fistula is apt to occur and the intestinal contents may cause an infection of the peritoneum, giving rise to a septic peritonitis, from which the patient may die.

After all of the diseased tissue has been removed it is wise to cover the abraded surfaces, as far as possible, with portions of the surrounding healthy peritoneum. If this cannot be done the sigmoid flexure should be brought down and placed across this portion of the pelvis, and if there is doubt about this remaining in position, it is well to fasten it by means of a few catgut stitches. The omentum should be brought down to this surface.

If the operation has been accomplished without causing rupture of the abscess, the surface should be sponged perfectly dry, the gauze tampons placed for the protection of the surrounding intestines should then be removed, and it is well to bring the omentum down from the small intestines so that these do not come in contact with the field of operation, because of the danger of distribution of infectious material by peristaltic motion.

If there is any doubt about the aseptic state of the field of operation, it may be well to place some form of drainage. This may be accomplished either through the abdominal wound, or by puncturing the vaginal vault.

The abdominal wound closed in usual manner.



The after-treatment is the same as for laparotomy for other causes.

I have purposely omitted mentioning conditions that may result from neglected infections.

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### CÆSARIAN SECTION—A CLINICAL CASE.

BY

C. I. WENDT, M. D., PITTSBURGH, PA.

ONE Saturday night about midnight I was called to the telephone by a colleague, who said that he had on hand a woman who had been in labor since 4 P. M., and that he was sure that there was a baby inside of her, but that he was unable to find it. I laughingly told him that he must have a navel presentation.

I saw the woman shortly afterwards, and, by examination, made out the position of the baby, the head being on the left side, and the buttocks on the right, and lying just above the pelvic brim, being an absolute cross presentation. On inquiring as to her history, the following facts were elicited:

She was 35 years of age—had been married for ten years, and this was her third pregnancy.

The first child was delivered after a great deal of trouble, by the use of the forceps, the head being badly damaged, and the child lived but a few hours.

In the second case, version was done, and the child delivered dead.

The husband was 60 years of age, and they were very anxious for a living child.

In my judgment there was too much risk to the child to do version, and I explained to the mother that Cæsarian section be resorted to. The husband at this time was eight miles away, in a small town, and was with difficulty located, and the situation explained to him, and his consent obtained.

An enema was given, and the lower bowel emptied; the abdomen was prepared by scrubbing with soap and water, shaving the vulva and abdomen, and thoroughly drying, and a dry sterile dressing applied. As soon as possible she was removed to the operating room in good condition. Ether was used, and the abdomen painted with iodine. A median incision extending

over an inch above the umbilicus to the pubis was quickly made, the uterus delivered, and while an assistant grasped the uterine arteries, an incision was rapidly made into the uterus lengthwise. This incision was enlarged with the finger, the child was grasped by the legs and delivered, the cord clamped and cut. Some little difficulty was experienced in extracting the child, as it was wedged in between the bones of the pelvic brim. The child was living and healthy. The placenta was delivered by peeling off with the fingers, clots wiped out and the uterus sewed up by two rows of cat gut sutures, the abdomen closed in layers, using silk-worm gut for the skin, silver foil and sterile dressings applied and the patient returned to her bed in good condition.

The first twenty-four hours were uneventful. At the end of that time, vomiting set in, at first largely water, but gradually assuming an olive green color. A slight distention of the abdomen at first, rapidly increasing until the abdomen was enormously distended. The vomiting became more frequent, and enormous quantities of olive hued water were thrown off, such large quantities and coming suddenly and with such force that two of the nurses were deluged. The abdomen, still enormously distended, was, nevertheless, soft, and the patient complained of some pain in different localities, mainly the upper part over the stomach.

The pulse rose to 140, respiration increased and was of a rather sighing quality. Auscultation over the stomach revealed a water wash. Palpation showed that the stomach was enormously dilated, the lower border being almost at the brim of the pelvis.

With the picture before us, a diagnosis of acute dilatation of the stomach was made. As the patient was getting rid of the fluid by means of vomiting quite rapidly, and as her mental condition was good, the quality of the pulse good, and as her feelings were improving and she expressed herself as comfortable, a stomach tube was not used, and in the course of twelve hours some gas was passed, and the distention of the abdomen rapidly disappeared. From then on convalescence was uninterrupted.

The baby was nursed by the mother, and on the fourteenth day she was sent home, and has since been perfectly well.

## BUREAU OF PATHOLOGY AND PATHOLOGICAL ANATOMY

J. D. ELLIOTT, Chairman

### ARTERIO-SCLEROSIS OF THE UTERINE VESSELS.

BY

J. F. FROSCH, M. D., PHILADELPHIA.

THE study of arterio-sclerosis of the uterine vessels has proved an attractive subject for nearly all gynecological and obstetrical pathologists, ever since Curveilhier gave the name of "Apoplexia Uteri" to certain cases of metrorrhagia apparently due to the rupture of a sclerosed blood vessel in the uterine mucosa and inner wall. This title was retained and the pathology of the condition was studied by von Kahlden, Herxheimer and others. Scanzoni, in 1859, and Cornell, in 1889, emphasized the fact that rigid and brittle vessel walls with a thickening of the uterus from sclerotic arteries was a definite cause of uterine hemorrhage. Findley, the first American to write on this subject, in 1901, reports a case of so-called "apoplexia uteri" due to an embolism of the uterine artery, which was probably cardiac in origin. In a later paper he attributes the hemorrhage to a muscular insufficiency because of an overgrowth of fibrous tissue, both between the muscle bundles and about the arteries. In 1903, A. Theilbar, while discussing chronic metritis, attributes the hemorrhage to an increase of connective tissue of the uterus at the expense of the muscle and calls the condition myofibrosis of the uterus.

In seeking a cause for this form of hemorrhage the early investigators considered the changes in the uterine muscle and blood vessels and not until the introduction of the curette was attention directed to the endometrium. This instrument rendering endometrial tissue freely procurable, led to an exhaustive investigation of same by a large number of workers, with the result that all irregular bleeding was attributed to changes in this structure, and an almost unlimited number of classifications and varieties of endometrial hypertrophies and endometrities was the consequence. Then our ideas concerning the



endometrium were revolutionized by the work of Adler and Hitschmann who have shown that much of that which was formerly considered pathologic in the endometrium is simply the normal change that occurs in the menstrual cycle. So that within the last three years there is to be noted a tendency for operators and clinical pathologists to again direct their attention to changes in the blood vessels and uterine muscle; and terms such as myofibrosis, uteriosclerosis, uterine fibrosis, arterio-sclerosis of the uterus, fibroid metritis, myopathic hemorrhages and arterial hypermyotrophy, used to designate a condition which has for its cardinal symptom, persistent menstrual and intermenstrual hemorrhage and yet exhibits none of the lesions commonly producing either menorrhagia or metrorrhagia.

In an effort to ascertain the cause and the pathology of arterio-sclerosis of the uterine arteries, it is not intended to review the entire literature on the subject, but shall refer to the more important articles, especially the writings and reports of cases by Reese, Anspach, Chalfant and Goodall.

As a result of a study of thirty-three puerperial uteri by J. R. Goodall, a very decided advance in our knowledge concerning the uterine blood vessels was made. He has shown that the uterus after each pregnancy develops a complete new set of arteries, that where the difference in size between the old artery and the new one is great as in the placental area, a complete new vessel with three new complete coats is formed within the lumen of the old one; but where the difference in size is less marked part of the old vessel is retained and is incorporated as part of the wall of the new vessel. Normally the unused portions of the walls of the old vessels undergo a hyaline degeneration and are completely absorbed, providing involution takes place quickly and completely. But in a very large percentage of cases local disturbances or constitutional conditions operate to prevent the complete absorption of these remains of the parent vessels, so that the change is less perfect and the media of the old vessel, after the hyaline degeneration has taken place is replaced by elastic tissue instead of muscle. This is an effort on the part of Nature to do the best possible under the conditions present. A study of the uteri of the parous women of Goodall's series shows that those who have borne children late in their sexual life have a strong tendency to retain unabsorbed remains of the hypertrophied vessels of their last pregnancies

and concludes that one of the most potent factors in causing the lack of tissue change preparatory to absorption is found in age and multiparity.

In an analytical study of sixty-two cases of persistent menorrhagia or metrorrhagia attributed to sclerosis of the myometrium and the blood vessels, reported in the available literature up to October, 1907, B. M. Anspach showed that a large number of these cases were complicated by lesions outside of the myometrium, such as displacement, fibromyomata, adenomyomata, carcinoma, pelvic inflammatory disease or advanced cardiac and renal lesions any one of which might have been responsible for the hemorrhage. He further states that a review of 2,500 cases in the gynecological service of the University Hospital showed that menorrhagia or metrorrhagia was a symptom in 49 per cent. of fibroids, 20 per cent. of retrodisplacements, and 19 per cent. of pelvic inflammatory disease. Proving that in a certain proportion of cases of retroposition, descensus and prolapse, pyosalpinx, ovarian abscess, chronic adhesive peritonitis and ovarian cyst, the symptoms include menorrhagia and metrorrhagia. Consequently, whenever these diseases exist, hemorrhage from the uterus cannot be attributed without reservation to a lesion in the myometrium.

In a detailed report of fifteen cases of intractable uterine hemorrhage for which hysterectomy was performed, B. M. Anspach, after histologically examining these uteri, concludes that almost without exception, arterio-sclerosis and myofibrous were present in direct ratio to the parity and age of the specimens and that a large proportion of the supposed hemorrhagic uteri were explainable upon other basis.

In a study of eleven uteri which were removed for the relief of hemorrhage, due to sclerosis, Chalfant states that four of the patients had probably had chronic nephritis as shown by the urinary findings. Two patients had recent operations for the repair of lacerations and bleeding became so severe while they were in bed, the performing of hysterectomy became necessary. Another one had a recent abortion and some mild infection with a consequent local congestion. The other case gave no history of anything that would seem to be an adequate exciting cause except that they were all beyond the age of 40 years. In concluding the report of cases permit me to include the clinical histories and microscopical findings concerning two uteri which

were removed for the relief of uncontrollable hemorrhage due to sclerosis of the uterine blood vessels and myofibrosis.

CASE 1.—Mrs. A. A. (patient of Dr. J. E. James, Jr.), age 67, 10 children, no abortions, menstrual history normal, menopause occurred at the age of 45 years. General condition.—Gives history of having attacks of angina pectoris.

For the past four years patient has been bleeding at irregular intervals. This continued and gradually became worse until one year previous to operation, when a consultant after an examination found the pelvic floor very much relaxed because of lacerations and the uterus freely movable but retrodisplaced. The performance of a diagnostic curettage was not permitted by the patient. The use of a pessary was resorted to and resulted in affording the patient relief for one year when a profuse and persistent hemorrhage occurred which demanded hysterectomy.

*Pelvic Examination.*—Vulva negative, perineum lacerated, cervix lacerated, posterior lip of cervix continuous with posterior vaginal wall and anterior lip was eroded. Uterus atrophic, freely movable and retrodisplaced. Adnexa negative.

*Gross Pathology.*—Uterus small and firm, palpable arteriosclerosis, vessels protrude from myometrium on section, uterine cavity contains a polyp.

*Endometrium* markedly thinned, penetrates here and there into myometrium, glands dilated (cystic) no evidence of inflammation.

*Myometrium.*—Blood vessels large and numerous which show calcareous degeneration, hyperplasia of intima, small vessels also affected.

The above history is that of a case in which the hemorrhage was evidently due to disease of the myometrium, but possibly in part attributable to a uterine polyp, displacement of the uterus, lacerated perineum and cervix, and general arteriosclerosis as evidenced by angina pectoris.

CASE 2.—Mrs. H. F. (patient of Dr. H. L. Leopold), age 52 years, eight children, two abortions. Menstrual history normal. General condition: heart good, urine negative. On June 14, 1911, uterine bleeding occurred and lasted for four weeks. In the month of November of the same year bleeding occurred which also lasted four weeks. In December, 1911, sustained a fracture of the patella and during the time that she was confined to bed uterine bleeding at irreg-



ular intervals occurred. The bleeding became uncontrollable and hysterectomy was performed.

*Pelvic Examination.*—Perineum, first degree laceration, cervix bilaterally lacerated. Uterus enlarged, not freely movable and retrodisplaced. Celiotomy revealed an enlarged and firm uterus and a marked varicose condition of the veins of the broad ligament.

*Gross Pathology.*—Uterus enlarged and firm. Both ovaries cystic. Uterus on section cut with difficulty, wall greatly thickened and has the consistency of fibrous like tissue.

*Microscopical Examination of Specimen.*—Endometrium thickened, glands increased in size and in a number of areas show cystic dilatation.

*Myometrium.*—Diffuse increase of fibrous tissue through all layers of uterine muscle. The walls of the blood vessels are greatly thickened.

A typical case of hemorrhage associated with myofibrosis of the uterine muscle but complicated by lacerated cervix, retrodisplacement, hypertrophied endometrium, varicosities of the broad ligament veins and ovarian cysts.

#### CONCLUSIONS.

A careful study of the foregoing case reports allows one to conclude that in a larger proportion of hemorrhage cases, the symptoms are not dependent upon any sclerotic changes in the uterine muscle and blood vessels but arise from endometrial hypertrophy lesions of the adnexa, varicosities of the ovarian and uterine veins and congestion of the pelvic blood vessels from general relaxation, cardiac or renal disease.

2. The arterio-sclerosis to which "apoplexia uteri," "myopathic hemorrhage," "intractable hemorrhage," etc., have been attributed is the normal sclerosis of the uterine vessels occurring in due proportion to the parity and age of the individual and cannot in justice be considered pathological.

3. It is rare but possible for arterio-sclerosis of the uterus to occur previous to the age of 40 years and then be pathological. This form of sclerosis follows a chronic metritis of which there are two forms, one following an acute metritis which has been severe enough to destroy some of the muscle tissue, the other being chronic from the beginning and intimately associated

with chronic infectious metritis, subinvolution of the uterus and pelvic congestion.

4. That the bleeding in this class of cases is frequently a local manifestation of a constitutional condition. There is no doubt that a weak or insufficient heart is frequently responsible for pelvic congestion with consequent menorrhagia or metrorrhagia, and it is only reasonable to suppose that an increase of blood pressure in the pelvic vessels from general arterio-sclerosis, cirrhosis of the liver, and a contracted kidney would have some result.

5. That a clinical diagnosis of arterio-sclerosis of the uterus is difficult to make and can only be made where it is possible to exclude every other cause of hemorrhage from the uterus.

6. That with the uncertainty of diagnosis even after examination of a section from the cervix and scrapings which show no evidence of malignancy in women between the ages of 40 and 50 years who give a history of multiparity and suffer frequent recurring hemorrhages, hysterectomy is justified.

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THE TREATMENT OF RETAINED FRAGMENTS OF FETAL MEMBRANES AFTER LABOR.—Roeder has reviewed the cases occurring at the Alexandria clinic for women in St. Petersburg, and among nearly 14,000 women delivered he found retention of fragments of fetal membranes in about 10½ per cent. This is about the proportion which v. Herff also observed. Of these 1,476 cases, 1,307 were treated passively, and 169 by active intervention. In 737 cases the fragments were spontaneously expelled; they remained in 570 cases therefore. It was found that if the fragments consisted of chorion, that they were dissolved; while if they consisted of amnion, the membrane usually appeared as such. These 1,307 cases were treated with secale, vaginal douches twice daily and possibly ice upon the abdomen. The active intervention in the 169 cases consisted in instrumental removal, sometimes the use of the curette, and douches. These cases have been examined from various viewpoints and the results were always in favor of the conservative treatment; thus of the conservatively treated cases 78 per cent. were afebrile, while the same was only true in 55 per cent. in the other cases. Of those cases which became febrile 21 per cent. had been conservatively treated, and 42 per cent. actively. The mortality was 0.23 per cent. in the conservatively treated cases, and 3 per cent. of those operated. The same favorable comparisons appeared when the duration of the fever was studied, and also its height. The author therefore draws very definite conclusions in favor of non-interference or rather conservatism, provided of course there is not present hemorrhage calling for intervention.—*Monatschr. f. G. w. G.* Vol. 35-671.

**SOME PROBLEMS IN GYNAECOLOGICAL DIAGNOSIS.**

BY

NORMAN S. BETTS, M. D., PHILADELPHIA.

(Read before the Germantown Homœopathic Medical Society.)

THE modern development of technique in the use of the X-ray, the examining and catheterizing cystoscope, the sigmoidoscope, the various hematological, serological and microscopic tests and the many instruments of precision now in common use have greatly perfected and broadened the field of abdominal and pelvic diagnosis.

Justly or unjustly, the gynaecologist has come to include at least the whole lower abdomen with the contents of the false and true pelvis in his sphere of work. The intimate relation between pelvic and abdominal pathology and the difficulty of making absolute diagnoses of intra-abdominal conditions before operation have made it necessary for the operator who opens the abdomen, be he gynaecologist, obstetrician or urologist, to be competent to cope with any conditions which may be encountered in the peritoneal cavity.

A paper then upon gynaecological diagnosis need not be confined to a consideration of purely pelvic disease. I wish to briefly sketch this evening some phases of the latest thought on the pathology and diagnosis of some of the more common morbid processes in the female lower intestinal and genito-urinary organs.

The number, variety and frequency of disorders of the right side of the abdominal cavity from the diaphragm to the pelvic floor is in striking contrast with those of the left side and greatly complicate the problem of correct diagnosis, especially when urgent symptoms call for immediate action or when abdominal and pelvic disease coexist.

Sudden severe pain in the right iliac region may be due to a number of conditions other than appendicitis. The impaction of a calculus in the right ureter, an ascending pelveoperitonitis, an ileocolic invagination, ruptured tubal pregnancy or pus tube, strangulation of an ovarian cyst, Dietl's crisis from a floating kidney, femoral hernia, volvulus and acute intestinal indigestion are only some of the possibilities to be considered. The history, symptoms and physical signs of all these condi-



tions are sufficiently characteristic to make accurate diagnosis possible in most cases if they are carefully elicited. Signs of appendicitis are almost too familiar to repeat. In cases where the appendix lies in the abdomen and the inflammatory process tends to self limitation the pain is constant, spontaneous, localized and aggravated by slight pressure. The right rectus is rigid and the ascending colon is distended. Meteorism and tenderness spread with the progress of the disease. Pressure in the neighborhood of the splenic flexure of the colon is apt to aggravate the appendiceal pain. Gastric disturbance, fever, general prostration and rapid pulse with a swelling in the right inguinal region which cannot be reached through the vagina and rectum complete the picture.

Differentiation from renal colic usually presents little difficulty. The constant change of posture contrasts with the quiet attitude of peritonitis. The soft abdomen, the full, slow pulse, absence of fever and direction of the pain will usually make the diagnosis obvious without ureteral catheterization or the X-ray. I have found pain on pressure in the back over the erector spinae muscles in the course of the ureter, of value in diagnosis.

In acute ileocolic intussusception the pain is also spasmodic, but becomes continuous when peritonitis is added. It is accompanied by tenesmus, bloody, mucous stools and the presence of a sausage-shaped tumor on the right side.

A pelveoperitonitis from the extrusion of infectious matter from a pus tube, or by tubal rupture, will give the history of puerperal or gonorrheal infection, and examination will show tubal and parametric induration in one or both sides continuous with the exudate in the inguinal region. There may be purulent leukorrhoea and evidences of previous infection of the urethra and Skene's glands. I have been impressed with the frequency with which cases of salpingitis give a history of presumed complete abortion with apparent rapid and entire recovery, but whose later trouble can only be traced to infection at this time. Tubercular infection of the tubes, which is not uncommon, occurs through the peritoneal cavity or blood.

The question of diagnosis and the propriety of surgical intervention assumes the greatest importance when the patient, following a sudden, acute pain in the right lower abdomen, passes into a state of collapse. Perforation of the appendix, acute intestinal obstruction, rupture of a tubal gestation or of a pus sac and strangulation of an ovarian cyst present them-

selves to our minds as the most frequent possibilities. The history should be elicited as carefully as possible, though this is often unsatisfactory. Follow this with abdominal, vaginal and rectal examination. All diseases in which the abdominal cavity is suddenly flooded with septic material present intestinal symptoms, principally produced by a combination of acute intoxication and nervous shock. There is a rapid, weak and perhaps irregular pulse, clammy perspiration, sunken eyes, dry tongue, cold extremities, rapid and superficial respiration and frequently sub-normal temperature. These symptoms may occur in strangulation of a cyst, bursting of a pelvic abscess and in perforation of the appendix. In the first two diseases, however, a tumor or infiltration in the pelvis with local tenderness can always be detected. An ovarian cyst with pedicle may have become almost entirely abdominal, especially as it tends to increase in size after strangulation, but its connection with the pelvis can nearly always be ascertained, whereas in perforating appendicitis such a massive exudate does not develop in so short a time, nor has it such a regular, rounded form. When the uterus is freely movable and the pelvis free from induration or growths, we are justified in considering the abdomen the seat of the disease. The pain in perforating appendicitis spreads rapidly over the entire abdomen and diminishes in intensity at the seat of the origin. Meteorism may be marked and even fecal vomiting may set in from intestinal paralysis. The pain of acute intestinal strangulation remains severe and constant at the same point;—even after the entire abdomen has become tender from complicating peritonitis, the area of strangulation can still be made out by its greater sensitiveness. Incessant vomiting, absolute constipation, excessive tympanites with local pain, and tenderness over the entire abdomen, are the chief symptoms of acute intestinal strangulation. The collapse at the beginning is not so marked; pulse and general condition may even remain good until peritonitis and stercoraceous vomiting set in.

The collapse following rupture of an extra-uterine pregnancy is, of course, due to the anemia from acute hemorrhage. A woman is suddenly seized with sharp pain in the iliac region, faintness, cold extremities, rapid, feeble pulse, etc., features which closely resemble those caused by the affections mentioned above. Still, some discriminating points can be made out. The face is deadly pale, the lips blue, repeated attacks of

syncope and dimness of vision occur. The patient takes a deep breath now and then, she gasps for air. The dyspnoea in the other diseases is different. The original agonizing pain subsides and she complains of a feeling of heaviness and fulness in the pelvis. The mental clarity is in contrast with the apathy or stupor of septic intoxication. The usual history and signs of ectopic gestation will confirm the diagnosis.

At the present time, perhaps greater interest attaches to the consideration of the more chronic conditions of the right abdomen. The flood of literature upon coecum mobile, coloptosis, Lane's kink, Jackson's membrane, etc., has thrown much light upon a large group of cases characterized by vague right-sided abdominal pain and symptoms due to chronic intestinal stasis. A fuller understanding of these conditions serves to explain the lack of relief following many operations for "chronic appendicitis," floating kidney, etc., in the past. Unless there is urgent need for haste no abdominal wall should be closed without examination of at least the region of the ileocecal valve, the appendix, ascending colon and gall bladder.

Time will not permit of a detailed discussion in this paper of these abnormalities in the neighborhood of the coecum and ascending colon. It is sufficient to say that the diagnosis is not difficult if we do not forget the possibility of kinks, torsions and prolapses in the etiology of chronic affections in this region. The X-ray here is invaluable. The use of bismuth salts, preferably the sub-carbonate, ingested with some bulky food or injected into the bowel from below gives us accurate data on the topography and motility of the entire digestive tract. Care and experience are necessary in interpreting our X-ray findings. Because we find the middle of the transverse colon lying a few inches above the symphysis pubis does not necessarily mean coloptosis, as some seem to think. We very frequently find the gut in this position when operating for entirely different conditions on patients who have no digestive troubles whatsoever. A downward displacement of the hepatic flexure with ballooning of the ascending colon is, however, very suggestive.

A new use for the X-ray in diagnosis is in the differentiation of pregnancy from large uterine myomata or other pelvic tumors. After about the fourth month of gestation the centres of ossification in the fetal bones may be made out in the X-ray plate. It must be remembered that calcareous deposits occur



with a fair degree of frequency in large uterine myomata, but their differentiation from bone development will present no difficulty.

In this connection, I would refer to the new serum diagnosis of pregnancy introduced by Professor Abderhalden and based upon the proteolytic enzyme action of blood serum from a pregnant woman upon test pieces of placenta.

The etiology and diagnosis in a small group of cases whose sole complaint consists of dysurea and frequent urination is frequently very puzzling when all the usual signs and symptoms of cystitis can be excluded. True inflammation of the bladder mucosa must be differentiated from simple frequent urination (pollakiuria), trigonal hyperemia, pelvic tumors, displacements and inflammatory conditions, urethritis, ureteritis, pyelitis, tuberculosis of the kidney, stone in the bladder or kidney and nervous diseases. One of the most distressing cases of dysurea, which I have seen, occurred in an elderly unmarried woman who was the subject of a severe diabetes. The cystoscope showed a marked trigonal hyperemia. Hyperacidity of the urine is also the causative factor in some nervous women.

It is well for us to remember that early tabes may affect the bladder. Other, less common, nervous diseases acting in the same way are compression myelitis, multiple sclerosis, tumors of the spine, cortical lesions of the brain and of the crossed pyramidal tracts. Hysteria is the factor in some cases, but this disease is often blamed for symptoms which a careful search will show to be due to anatomical causes. Do not forget the possibility of fistulae leading from pelvic abscesses as a cause of pyurea.

The predominance of right-sided affections of the abdomen seems to also apply in affections of the ureters in my experience. It may not be generally understood that the lower ureters can be readily palpated in the vault of the vagina when tender and thickened by inflammation.

The enlargement of a normal gravid uterus may occasionally result in septic urethritis by pressure during the early months. I recently saw in consultation a case of this kind in desperate septic condition with a temperature reaching 100 degrees, in which the temperature dropped to approximately normal, and remained so, within twelve hours after I emptied the

uterus. Only the right ureter was affected in this case, and she made an uninterrupted recovery.

A case which is of considerable interest from a diagnostic viewpoint, as well as on account of the long duration, is briefly as follows: A married woman of 47 showed symptoms resembling early typhoid fever. She gave the history of having felt something "give way" in her right side while jumping in the school yard as a child of 14. An eminent Philadelphia physician of that time made a tentative diagnosis of bowel obstruction which was later changed to cyst of the broad ligament. Symptoms improved under medical treatment, but in her own phraseology, all her life she "had to favor that side." In the light of subsequent knowledge her symptoms pointed to an intermittent hydronephrosis from a floating kidney. Physical examination at the time of my attendance showed a large, tender mass extending vertically through the right abdomen and having the colon in front of it. Cystoscopic examination showed an impermeable right ureter. Diagnosis of pyonephrosis was made and at operation about two gallons of pus were drained from the ureter. The remains of the right kidney were removed during the past summer and the patient now seems perfectly well.

One more case I wish to cite in illustration of bladder symptoms of obscure etiology. A well developed, married woman, aged 40, presented herself for treatment of symptoms which dated from a fall from a carriage in a runaway. She complained of frequent urging and dysurea for which she had been treated by a well known genito-urinary specialist of New York who had called a professor of gynaecology in consultation. A most thorough general and local examination including X-ray and cystoscopic inspection of the entire urinary tract failed to show why a hyperemia of the posterior wall of the bladder continually recurred after being temporarily cured by local treatment. An ulcerated spot near the beginning of the urethra had also been found. Repeated bacteriological examinations were negative.

I was just at that time especially interested in the subject of coloptosis and some rather vague digestive and neurasthenic symptoms which this patient presented led me to have an X-ray picture taken of her large bowel. This showed that the transverse colon rested directly upon the bladder and the hepatic flexure was markedly displaced downwards. At operation the

hepatic flexure was fastened in its normal position and the transverse colon stitched to the great omentum in four places. She has had no recurrence of bladder trouble, but a mucous colitis and symptoms of mild intestinal indigestion remain resistant to treatment.

No field of differential diagnosis offers more difficulties than that of the abdomen. In this paper I have for the most part sketched the symptoms of the clear cut cases, but many cases are atypical and in the present state of our knowledge mistakes are inevitable; indeed, I may say that some conditions are absolutely undiagnosable before the abdomen is opened and its contents inspected.

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**SYPHILITIC AORTITIS.**—Syphilis of the blood vessels has only recently received the attention which it deserves. Although older practitioners, who were good observers, conjectured the relationship between syphilis and changes in the blood vessels, it remained for Heller to place specific disease of the aorta on a firm and definite basis. The anatomical picture of the interior of the aorta is characteristic of the disease. There is an irregular folding of the inner surface with marked thickening and sclerosis at the points of exit especially of the larger vessels, and the latter are often encroached upon and distorted. These changes stop abruptly at about the junction of the thoracic and abdominal aorta. This fact constitutes an important point in the differentiation between syphilitic and non-syphilitic arteriosclerosis. In this disease there is easily produced a weakening of the vessel wall, loss of elasticity, irregular dilatation of the aorta or even aneurism formation. In some spots the vessel wall may become so thin that it is translucent.

Syphilitic aortitis is a relatively common disease. It has been found by some pathologists in more than 80 per cent of all syphilitics coming to the autopsy table, while in syphilitic new-borns it has been found in as many as 60 per cent of the cases. This disease occurs frequently in early middle age, at which time non-specific arteriosclerosis is less apt to be observed.—*Med. Rev. of Reviews.*

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**POST-OPERATIVE PAROTITIS.**—Bacharach (Vienna) reports the following case: After making a fistula into the jejunum for the purpose of nourishing the patient, because of intestinal hemorrhage, a parotitis developed. Since the operation wound remained perfectly clean, and on the other hand since nutrition was only carried on through the fistula, this case seems to warrant the view that the parotitis developed from infection from the mouth in consequence of the exclusion of the function of this gland by extra oral feeding.—*Obstr. Zentralbl. f. Gyn.* 1912-1233.



## EDITORIAL

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### THE COMMENDABLE ACTIVITY OF THE OFFICERS OF THE AMERICAN INSTITUTE OF HOMŒOPATHY.

WE feel that a word of praise should be spoken in commendation of the efforts that are being made by the officers and chairmen of the various committees of the American Institute of Homœopathy to enlist the interest and attention of the members of the homœopathic profession in the coming meeting of the Institute to be held at Denver from July 6th to July 12th.

President Hinsdale has published a number of communications in various homœopathic journals calling on the members of the Institute to boost the Denver meeting and has been ceaseless in his activities to provide for the social and scientific entertainment of all who attend.

Dr. James C. Wood, chairman of the Committee on New Members, is also putting forth every effort to make this year a banner one as far as the number of new members is concerned. When we consider that of the fifteen thousand homœopathic physicians in the United States and Canada, but twenty-seven hundred are members of the American Institute of Homœopathy, it is evident that there is a wide field for the activity of this committee.

The time is at hand when the homœopathic physician should realize the importance of a strong state and national organization of our school. All over the United States restrictive and proscriptive medical legislation is being put in force. While many of these measures do not affect the individual physician now in practice particularly, there are others, such as the laws that have been proposed in many legislatures which would prohibit the physician from dispensing drugs, that would seriously and even vitally affect the practice of the individual practitioner of homœopathy and the interests of our school as a whole.

With a view of inducing the great body of homœopathic practitioners to go into the Institute this year, the admission fee has been reduced to one dollar for the first year, two dollars the

second year, three dollars for the third year and four for the fourth year, and thereafter five dollars a year.

Subscription to the Institute journal is one dollar a year to members. Any physician can go into the Institute therefore for the small sum of two dollars which includes one year's subscription with the Institute journal.

The local committee of Denver physicians has also done good work and is preparing, with the characteristic spirit of the West, to give the members a rousing welcome and to make the social end of the meeting an unusually attractive one.

The American Institute of Homœopathy is an up-to-date, progressive, medical association and every homœopathic practitioner should consider it not only an honor but a privilege to enlist himself under its banner in the cause of progressive homœopathy.

G. H. W.

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#### VACCINE THERAPY IN EUROPE.

WHILE we are in the midst of a wave of enthusiasm for vaccine therapy in the United States, and almost every bacteriologist, and certainly every commercial firm supplying bacteriological products, feels called upon to devise a new vaccine for every disease, it is of interest and possibly of value to learn the attitude of European physicians toward vaccine treatment. A recent writer on this subject states that he had the opportunity of investigating the subject in various parts of Europe, and finds that European physicians seem to have little confidence in the use of vaccines and that such preparations are rarely employed by them in the treatment of disease.

In England, vaccine therapy is used more extensively than on the Continent and even there vaccine therapy is rarely employed. The author of these observations attributes the failure of the European physician to employ vaccine to their ultra conservatism and also to the spread of therapeutic nihilism which is prevalent abroad. He states that European physicians find that they have no trouble whatever in getting their patients to follow out strictly any treatment prescribed and that they do not feel the necessity for securing rapid results. Whether this observation is correct or not, we are unable to say; but if such is the attitude of patients abroad, we feel justified in saying that a European physician would find himself in a very unpleasant

environment should he take up the practice of medicine in the United States, and we wonder at the temerity of Dr. Friedmann in leaving such ideal surroundings to exploit the use of his tuberculosis cure in America.

Perhaps, however, the well known enthusiasm of Americans for "something new," regardless of its merit or demerit caused him to look favorably upon America as a field for his activities. In any event he will find no opposition in this country to the use of his vaccine treatment, as measures of this sort command, for the present at least, universal approbation on the part of the laity and of the medical profession.

G. H. W.

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#### INJECTIONS OF ISOTONIC SEA-WATER AS A THERAPEUTIC MEASURE.

DURING the last two or three years a large amount of clinical data has been collected relating to the use of isotonic sea-water in the treatment of a large variety of diseases. The results of this experimentation would seem on the whole to be encouraging, and this agent appears to have considerable value in the management of certain diseases that have hitherto been resistant to the usual methods of treatment.

The use of isotonic sea-water was first suggested by René Quinton, who believes that the primitive cells obtained their nourishment direct from the ocean and that the saline concentration of the primordial ocean was the same as that of the human plasma.

In using sea-water for therapeutic purposes, it is customary to obtain it at a distance of several miles from land and from a depth of at least thirty feet. After the sea-water has thus been collected in sterilized bottles it is mixed, after filtration, with spring water, in the proportion of two parts of sea water to five of fresh water. The mixture is then frozen and later filtered twice through a germ proof filter and stored in glass ampules.

Dr. Sandberg, in an interesting article in a recent issue of the *British Medical Journal*, advises the following technique as the result of his extensive experience with this agent: The skin of the patient should be cleansed with alcohol and about fifty cubic centimeters injected into the buttocks three times a week. After four injections of fifty centimeters have been given, the dose should be increased to one hundred cubic centimeters and administered twice weekly.



According to those who have written on the subject, the effects of the injection of the plasma are quite quickly observed. A marked reaction with rise of temperature ranging from 100 to 102 degrees usually follows the first or second injection, but this phenomenon does not manifest itself after the use of the third injection. Increased weight, improvement of the appetite and a gain in general strength are said to be manifest shortly after the reaction subsides.

Among the diseases that are said to have been materially improved by isotonic sea-water may be mentioned rheumatoid arthritis and a great variety of gastro-intestinal disorders, especially mucous colitis.

In the treatment of rheumatoid arthritis, it is advised to give the injections twice a week. In the cases reported it seems to have been necessary to continue the treatment for about three months or longer.

Hawkes, of London, has been strongly impressed with the value of isotonic sea-water in mucous colitis, and reports one case that existed over eleven years that was cured in less than seven months by the use of sea-water injections.

Those who have employed this agent state that there are no ill effects observable from its use. The injections are said to be painless and cause no inconvenience to the patient.

G. H. W.

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**WHY EVERY HOMŒOPATHIC PHYSICIAN IN THE UNITED STATES AND  
CANADA SHOULD IDENTIFY HIMSELF WITH THE AMERICAN  
INSTITUTE OF HOMŒOPATHY.**

BY

JAMES C. WOOD, M. D., CHAIRMAN OF MEMBERSHIP COMMITTEE.

1. THE American Institute of Homœopathy is the oldest national medical organization in the United States.

2. It has during its 69 years of existence protected and safeguarded your interests in all matters pertaining to medical legislation and the regulation of medical practice.

3. It is the national organization of *your* school of medicine. As a matter of loyalty and pride, you should be identified with that organization.

4. It is utterly impossible for you to keep in touch with

what your school of medicine is doing without having at your command the transactions of the Institute, in which are published not only the proceedings of the Institute but all of its scientific papers.

5. It is the most liberal medical organization in the world.

6. Its members are composed of men representing all views regarding the potency question, and there is no good reason why every homœopathic physician in the United States and Canada should not affiliate himself with the organization.

7. No homœopathic physician can afford to miss the meetings of the Institute. No one can attend these meetings without returning from them refreshed in mind and body, and in much better shape both physically and intellectually to do his work during the remainder of the year.

8. There never was a time in the history of medicine when it was more important for every homœopathic physician in the United States and Canada to have back of him a strong national medical organization. Legislation of the most important character is being carried on throughout the country and there is serious danger of legislative enactment inimical to your professional standing in the community in which you are practising. Only constant watching by a strong national organization will prevent this.

9. There are approximately 15,000 homœopathic physicians in the United States. Of this number but 2,700 are members of the national organization. With a view of getting every homœopathic physician in good standing in the United States and Canada into the Institute, the dues have for the first time been reduced for the first year to one dollar, the second year to two dollars, the third year to three dollars, the fourth year to four dollars and thereafter to five dollars a year.

10. Subscription to the official journal is but one dollar a year to members so that it will cost you but two dollars to become a member of the Institute and receive the official journal. The official journal is a monthly publication and provision has been made so that at a small cost it can be bound at the end of the year, giving you each year a splendid volume for reference to be placed upon your shelf.

Will you, doctor, send in your application? You need the endorsement of the Institute and the Institute needs your endorsement.

## A COMMUNICATION.

CLEVELAND, OHIO, March 26, 1913.

*To the Members of the Homœopathic Profession:*

MY DEAR DOCTORS:—The reports from the Council of Medical Education show that the efforts to secure pledges, re Propagandistic work, have been encouraging. However it appears to some of us that we must resort to more effective and strenuous methods to secure the pledges from a large number of our physicians who have not yet subscribed. As the originator of this method for securing the pledges from every homœopathic physician, namely, \$2 or more a year for five years, and among the early promoters of the propagandistic and evangelistic work I am deeply interested in its ultimate success. The plan as presented has already awakened an interest all along the line and the interest *must be kept up*. How shall it be done? It is very essential that all the journals should lend a helping hand, through their editorials, thereby indicating the importance of the work and urge their readers to respond to the efforts being put forth for propagandizing and evangelizing. Would it not be well for the Council of Medical Education to give to the profession monthly reports of the results of the efforts obtained by the Director, publishing the names of those who have given pledges and the amounts subscribed, in all of the journals, and especially the Official Journal of the Institute?

Where the first appeal has failed to secure a pledge it should be followed by another more pronounced and if necessary repeated until the pledge is obtained. The "Spread of the Gospel" and "Team Work" editorials in the February and March numbers of the Official Journal of the American Institute of Homœopathy are timely editorials, and good results are sure to follow. Though I cannot endorse all of the suggestions of Dr. Cassaday, as stated in his "Plan to Place Homœopathy on the Proper Basis," etc., the doctor has advanced some very good and practical suggestions, and even if not altogether approved by the entire profession his suggestions, and those from others show that there is an awakening all along the line for the advancing of homœopathic interests.

Much praise is due to the Council of Medical Education for the vigorous efforts to secure pledges and especially to Dr. W. A. Dewey, the Secretary of the Medical Council and the Director of the Propagandistic work.



We are certainly awakening from our lethargy, the result of a long period of successes and triumphs, and it is necessary for us all to keep ourselves aroused and wide awake to the importance of the cause, and thus working strenuously and unitedly with this aim in view the victory will surely be ours.

The business methods adopted by the Trustees of the American Institute of Homœopathy, the energetic President Hinsdale, ever on the alert for homœopathic interests, and the inauguration of the College Alliance of the American Institute of Homœopathy, all betoken a bright future for homœopathy.

I feel confident that if this plan for securing pledges is vigorously pushed that sufficient funds will be received to carry on the work and the co-operation of the entire profession secured. It is endorsed by the Institute, and the Council of Medical Education is fully and duly authorized by the Board of Trustees to carry on the work. We must not forget that it is a work of love; that the Director and Sub-Directors are all working without any financial remuneration. The pledges and moneys collected by the Council of Medical Education are turned over to the Treasurer of the Institute, and the Institute, through the Board of Trustees, are the advisors as to the distribution of the funds thus collected, and we have confidence and faith that the funds collected are thus safely guarded and that they will be economically and wisely distributed.

I think the efforts to stimulate us to greater activities, and to spur us on in this important and vital propagandistic work, are most gratifying, and I am very optimistic as to the results, if we all put our shoulders to the wheel and work with a determined effort to advance the interests of homœopathy.

Yours fraternally,

A. T. BIGGAR.

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THE ACTION OF SPARTEINE.—George E. Pettey (*American Journal of Surgery*, July, 1912) says that sparteine sulphate lessens the frequency and increases the force of the heart action, but does not raise the blood pressure. It is a nonirritating, diuretic, and is free from objectionable effects.

## GLEANINGS

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PANCREATIC LYMPHANGITIS AND CHRONIC PANCREATITIS.—It is but a short time since the pancreas was but little considered by the clinician or by the pathologist. Tumors, chiefly carcinoma, by their size or effect, occasionally thrust themselves into notice, and a few cases of marked pancreatitis, if acute, were recognized clinically and, if chronic, were noted in the archives of the pathologist. In the midst of the general apathy on the subject came the observation of surgeons that the pancreas was to be found in various states of enlargement, induration, distortion or contraction in many cases of upper abdominal disease.

It seemed a natural inference that the pancreatic alterations associated with gall-bladder disease resulted from infection of the pancreas secondary to biliary infection and that the transference took place by way of the ducts, opportunity for which was provided by the usual junction of the two ducts to form the sinus of Vater. There are certain objections to this easy explanation. Pancreatitis is more common in males while gall-bladder disease is more common in females. Again, the pancreas is often diseased without demonstrable disease of the biliary tract. In a series of cases which the writer analyzed with reference to this point 36 per cent. of all instances of chronic pancreatitis and 25 per cent. of the cases of acute pancreatitis were not accompanied by disease of the biliary apparatus.

There are three other possible avenues by which infection may reach the pancreas: (1) Through the general circulation, (2) by direct contiguity from adjacent structures and (3) by way of the lymphatics.

1. There is little or no evidence in favor of frequent infection by way of the systemic circulation.

2. Infections by direct contiguity occur most often in slowly perforating ulcers of the stomach and duodenum. These are seldom in evidence in pancreatic disease, and when they do occur the portion of pancreas affected is that in immediate contact with the adherent viscus, while the remainder of the organ, as a rule, escapes material injury.

3. The lymphatics in the writer's opinion play a conspicuous role in conveying infection to the pancreas. Hoggan had previously shown a direct communication with the thoracic duct. Franks has shown that the lymphatics from the gall-bladder course immediately over the surface of the pancreas and then anastomose with the lymphatics of that organ. Bartel has shown the same direct relationship of the lymphatics of the duodenum and the writer believes, from clinical observation, that the lymphatics from the appendix pass upward and eventually are in close relation with the pancreas.

Chronic pancreatitis, when it has progressed to the stage of interlobular and interacinar fibrous deposit, is no more curable than is cirrhosis of the liver or chronic nephritis. Before the sclerosing process has taken place

the lymphangitis pancreatica may be relieved, like lymphangitis elsewhere by removal of the primary source of infection. The swellings of the pancreas that are seen at operation in association with gall-bladder disease are not usually due to any permanent tissue deposit but to edema, congestion and perhaps absorbable cellular infiltrates. These are reabsorbed on subsidence of the exciting inflammation. The essential point in the treatment is to get rid of the foci of infection in the abdomen to which the pancreatic swelling is secondary.

Not only are the essential symptoms of pancreatitis indefinite but the frequent association of pancreatitis with other abdominal lesions adds complexity that has so far foiled any attempt to formulate a clear-cut syndrome of early pancreatitis by means of which it may be recognized or suspected. Chronic pancreatitis possesses in common with chronic gastric duodenal and biliary disease the property of exciting more or less epigastric discomfort, distress or pain which may radiate to the hypochondria or the back. Nausea or vomiting are caused by some cases of pancreatic disease. The cause of our difficulty in recognizing pancreatic disease is to be found in the absence of definite physical signs and our inability to recognize slight functional derangements of that organ. When the disease is well marked a swollen indurated pancreas may occasionally be palpated and evidence obtained by examination of duodenal contents and study of the feces showing decrease or absence of pancreatic ferments. When the islands of Langerhans are extensively diseased glycosuria is an accompaniment that is easily recognized. The Cammidge reaction has given the writer little or no aid.

The writer believes that carcinoma of the pancreas is in many instances brought into existence by previous pancreatitis.

The treatment of pancreatic lymphangitis consists in the various measures which are efficacious in removing the primary source of infection. In one case removal of a chronically diseased appendix may be indicated. In another appropriate treatment for gastroduodenal catarrh or duodenal ulceration. Clinical experience, however, shows that the majority of cases of early pancreatic inflammation are closely related to disease of the biliary tract and are most favorably influenced by the measures that tend to restore the biliary passages to a state of health. The great principle of the treatment of biliary disease is drainage. Gall-bladder drainage is the sheet anchor in the treatment of pancreatitis. Not only is the gall-bladder sterilized by cholecystostomy but the catarrhal cholangitis of the common and hepatic and lesser ducts, which frequently accompanies gall-bladder disease, is also relieved. Many cases of mild pancreatitis are completely and permanently relieved by simple cholecystostomy with drainage continued for from four to eight weeks. In cases requiring cholecystectomy drainage should be instituted by choledochostomy. Occasionally, and only in the hands of an expert cholecystoduodenostomy may be done. The technical difficulties of this operation are very great and the writer has found that even this anastomosis does not necessarily ensure permanent drainage. Another point to be observed in all cases in which jaundice is a feature of pancreatitis is the opening of the common duct and the passage of a sufficiently large-sized probe into the duodenum to secure full dilatation of the duct and the opening of the papilla of Vater.



In conclusion, after repeating several statements sufficiently covered in this abstract, the writer states "that pancreatitis is common and not rare and that its presence should be suspected in all cases of obscure upper abdominal indigestion and that like other chronic inflammatory lesions of the abdomen when it is uninfluenced in a reasonable time by medical measures it should receive surgical attention along the lines here proposed."—*Dr. John B. Deaver (Journal A. M. A., January 4, 1913.)*

**RENAL TUBERCULOSIS.**—By *Dr. M. Maclaure (Gazette des Hopitaux, April, 1912).*—Usually the diagnosis of renal tuberculosis is comparatively easy from a consideration of the following symptoms and signs: Pyuria not disappearing with rest, hematuria, lumbar pain, renal enlargement, and lastly the presence of tubercle bacilli in the urine. In difficult cases the inoculation of animals with the urinary deposit is necessary. Cystoscopy and catheterization of the ureters confirm the diagnosis and fix the site of the lesion.

At the onset renal tuberculosis is commonly unilateral (Vigueron found 90 cases of unilateral renal tuberculosis in 205 cases). In post mortem examinations either one kidney is free of infection or if the disease is bilateral the infection of one kidney is nearly always much more recent than the other.

Albarran distinguished the following forms of renal tuberculosis:

1. *Miliary tuberculosis*, which is characterized by the presence in the cortex of numerous miliary deposits.

2. *Nodular Infiltration.*—This results from the fusion of the former variety into islets in the cortex where they form yellow nodules of varying consistence.

3. *Massive Tuberculosis.*—The nodules described above become confluent and the parenchyma is replaced by a greyish soft, putty-like mass. This form is rare.

4. *Cavernous Tuberculosis (tuberculose caverneuse).*—This is the commonest variety; it is produced by the caseation of the nodular infiltrations which form irregular cavities which do not communicate with the pelvis.

5. *Tuberculous Hydronephrosis.*—This is very rare and is due to blockage of the ureter after evacuation of the purulent contents of cavities in the kidney.

6. *Tubercular Pyelonephritis.*—This is due to a secondary infection by pyogenic organism on top of a tubercular infection.

Secondary perirenal infection is very important. Sclerosis of the perirenal fat is common; definite tuberculosis of the perirenal tissues with or without caseation also occurs as also does infection of the glands in the neighborhood. These lesions are important as they may cause adherence of the affected organ to surrounding structures.

Secondary descending infections of the ureter, bladder, seminal vesicles, testicles, etc., are well recognized.

The age incidence is between 13 and 30 years; females are more commonly affected than males (Albarran).

Very commonly tuberculosis of the kidney is secondary to some other forms of infection in the body. Indisputable post mortem evidence of tuberculosis confined to the kidneys is however available, and many patients

have remained in health after extirpation of a tuberculous kidney, showing that at any rate any associated infected focus is of slight importance.

The mode of infection is commonly by the blood stream; lymphatic infection as in Pott's disease occurs; an ascending infection is doubtful although it may be obtained experimentally.

The treatment of renal tuberculosis is both surgical and medical; medical treatment consists in good food, rest, and good air. For surgical treatment three methods are available; nephrostomy, partial nephrectomy, and total nephrectomy.—*Post. Graduate*.

EXTRA-CARDIAC CAUSES OF FAILURE OF COMPENSATION IN VALVULAR DISEASES OF THE HEART.—By *Dr. Stengel (Amer. Jour. Med. Scs., January, 1913)*.—The author emphasizes the error of the clinician in looking to the pathological anatomist for data regarding cardiac pathology, ignoring the physiological features. Methods of treatment of circulatory disturbances, therefore, need revision. The return circulation is almost entirely due to agencies outside the heart, and to it the clinician must give his thought when the causes of failure of compensation are under consideration.

A person with some cardiac disease may maintain adequate compensation until arteriosclerosis lays increased stress upon the heart. Certain vasomotor conditions operating upon the arterioles may be the occasion of cardiac overstrain, as in renal disease the constant hypertension of the arterial system tends to exhaust a normal heart and even more speedily one already crippled by valvular disease.

The vasomotor mechanism is mainly operative upon the arterioles. The integrity of the whole mechanism is dependent not only upon the normality of the arterioles and the nerve centers and fibres that make up the vasomotor system, but also upon various internal secretions or products of tissue metabolism. The low blood pressure of Addison's disease and the high pressure of nephritis may be cited as extremes of the latter.

The splanchnic circulation is involved in vasomotor influences. One of the commonest types of anginoid conditions of the heart occurs in over-fed men with large and perhaps somewhat pendulous abdomens, probably resulting from myocardial disturbances following long-continued over-feeding, probably affecting the splanchnic circulation.

The author further considers the effect of respiration on the circulation, the effect of the quality and mass of blood and the conservative relations of liver and spleen to the general circulation.

He thinks that the causes of final cardiac failure are largely outside the heart itself.

HEREDITARY SYPHILIS OF THE NERVOUS CENTER.—(*Le Monde Medical*, No. 461, Sept. 5, 1912).—The following abstract of an article which appeared in *Le Monde Medical* on the 5th of September, 1912, is of sufficient importance to merit careful attention. These observations may serve to explain many forms of nervous disorders observed in infancy and early childhood, evidently having their origin in the brain and spinal cord. They will serve to direct the attention to the possible existence of hereditary syphilis. The use of the Wassermann test as a support of diagnosis in all doubtful cases is strongly to be recommended.

Congenital hydrocephalus is an hereditary manifestation of tertiary hereditary syphilis, or a dystrophy.

If it occurs as a type of dystrophy, existing at the time of birth, treatment is of no avail. It is often quite otherwise with the tertiary syphilitic form which may be preceded by cutaneous and mucous manifestations of this disease and which can be greatly improved, and even cured, by mercurial treatment.

Hydrocephalus, the result of tertiary hereditary syphilis, develops as a rule after birth. It manifests itself by the enlargement of the fontanelles, and of the sutures, and by the presence of a marked subcutaneous dilatation of the blood vessels, showing clearly through the skin. The size of the head is increased, the forehead is bulbous and Olympian. The children are mentally slow, and often present well marked signs of an intellectual feebleness, extending in some cases even to idiocy. They are slow in learning to walk, frequently have attacks of convulsions, and but rarely reach maturity.

It is often possible to observe in the hereditary tertiary syphilitic type a series of disturbances dependent upon a great variety of lesions, caused by the alterations in the meninges, and arteries and by gummata. The results depend upon the location of these lesions.

Hereditary syphilis of the cerebro-tertiary type may have *four* forms of invasion: the *convulsive* or *epileptic* form, the *cephalgic*, the *mental*, and the *apoplectic*, or *hemiplegic* type.

The *convulsive* form is the one most frequently encountered. Many cases of eclampsia of an indeterminate nature are really due to hereditary syphilis. Sometimes the autopsy is negative, sometimes, however, changes in the meninges are noted.

A certain number of cases of epilepsy are really of syphilitic origin, and may be cured by the administration of iodid of potassium. Sometimes the convulsive attacks take the form of Jacksonian epilepsy which indicates the specific character of the trouble.

The *cephalgic* form is characterized by a very severe headache, more or less violent, persisting through the night. As Professor Fournier has remarked, many cases of cephalalgia, existing since birth, are due to hereditary syphilis.

The *mental* forms of the disease are characterized by the diminution of the intellectual faculties, by loss of memory, by irritability, or by indifference. Sometimes these symptoms suggest a tuberculous meningitis. It is necessary to carefully investigate the antecedents of the family, and to begin mixed treatment as soon as possible.

The *apoplectic* form described by Professor Gaucher was based upon a single case. This was a young woman, twenty years old, who had an apoplectic seizure, followed by a hemiplegia, and who was cured by specific treatment in three weeks. She later developed gummata, which confirmed the diagnosis originally based upon the demonstration of specific alterations in the teeth.

Other phenomena characteristic of hereditary cerebral syphilis, but more rare, are *vertigo*, *vomiting*, and *paralyses of various cranial nerves*.

The cerebral lesions of hereditary syphilis of the tertiary type are very variable, and as a result the symptoms themselves are manifold. Diagno-



sis is difficult in the absence of all history. Meningitis, true epilepsy, or cerebral tumors are often suggested. The Wassermann reaction should be a great help in diagnosis.

Recognition of the medullary disturbance of hereditary syphilis are not less interesting. These troubles are also multiple. *Two types* are observed: the *embryonic meningo-myelitis*; and the *sclerotic form of pachymeningitis*, and *sclerotic gummata*. These lesions lead to polymorphous manifestations, which frequently coincide with cerebral symptoms, and with visceral lesions.

The various types of this disease which may be encountered are:

*Spinal paralysis*, with pain more or less active, or mild disturbances of sensation (tingling, numbness, etc.)

The *superior cervical* type, early or late, accompanied by spasmodic paralysis, contractures, disturbances of the sphincters, etc.

The *dorso-lumbar* type, a late manifestation. This is a form of transverse myelitis with spasmodic paralysis.

Finally, a form of the disease is observed closely simulating the locomotor-ataxia of Friedreich. Raymond has described an amyotrophic form.

Nerve lesions have rarely been noticed.

In all doubtful cases specific treatment should be thoroughly tried.—*Post-Graduate*.

TREATMENT OF ACUTE SUPPURATIVE OTITIS MEDIA.—Woods (*British Medical Journal*) emphasizes the importance of preventive measures. In mild cases of acute otitis media keep the patient in an even temperature, administer a purge, and apply moist heat locally. If thought necessary, warm drops (glycerin and water equal parts) may be instilled in the ear. If the tympanic membrane is bulging, myringotomy should at once be performed, and if there is any indication of spread of infection the mastoid antrum should be opened. In cases where suppuration has occurred and the discharge is coming through a perforation in the tympanum the indication is to remove the discharge from the meatus by syringing with sterile water, or better, slightly alkaline lotion, three or four times daily. After careful syringing the ear should be dried. Then—twice daily—after syringing and drying, the meatus should be filled with some antiseptic either in the form of a lotion, or a powder, such as boric acid. The author uses "boralcohol," which is a saturated solution of boric acid in 40 to 45 per cent. alcohol. Claude Rundle has found that horse serum—preferably diphtheria antitoxin serum—has a distinct value in otitis media complicating the acute stages of the infective fevers. Gustav Alexander advocated early paracentesis when conservative measures (such as instillations of carbolic glycerin, or a warm solution of aluminium acetate, or cocaine, novocaine, or alpine instillations) failed to give relief. The internal administration of hexamethylene tetramine (formamine) was of undoubted value and it was essential that large doses should be given. Children required half a gramme twice daily, adults four to six times daily. If the purulent discharge became serous the drug might be stopped. He also recommended the drug for prophylactic use (against post-operative meningitis) and in cases of meningitis of otitic origin.

THE FUNCTION OF THE FAMILY PHYSICIAN.—In this day of specialism

and specialists, we occasionally hear some one deploring the passing of the family physician; and while it may be, and doubtless is, true that this individual is not the "all in all" that he used to be, it is also true that there is, was, and always will be a place in the system of things which he, and he only, can fill.

By the term "family physician" I do not allude to the specialist in internal medicine any more than to any other specialist, but to the man who is the general family adviser of his various clients. He must be a good all-round man; an acute and competent diagnostician, both of medical and surgical conditions; an exact and skillful therapist; a psychologist of parts; and a diplomat at all times. In his professional relations the sphinx must be loquacious in comparison with him; and he must have sinned and suffered enough so that his sympathies and understanding will be catholic and all-inclusive.

He need not be a surgeon, nor a practical pathologist, nor deeply versed and experienced in some of the lines of his profession which require a delicate and hard-earned manual technique; but he must make up for any lack in these directions by a diagnostic skill which will enable him to recognize *at once* when the necessity arises for the services of any of these special workers.

In more than half of his cases his function is that of a confessor and adviser; mankind (particularly women) is prone to confess to some one, and as the consolations of the Romish confessional are not available to every one the family physician becomes the receptacle for the griefs and fears, the remorse and despairs, the doubtings and questionings of his clients; and upon his ability to dispense comfort and encouragement, absolution and hope, faith and instruction to his patients depends his success in his chosen work.

Few of his patients need much medicine; fewer still require surgical treatment; but they all need *advice*—kind words, gently spoken, or the ringing rebuke in no uncertain terms—they all come to him for *help*, and he must not fail them. Nor must he, in remembering all these things, forget that there is frequently a basis of altered function or structure lying at the root of some of the abnormal psychic states with which he has to deal, nor fail to recognize, promptly, when such is the case and apply the appropriate remedial measures, or call in such expert advisers and helpers as may be necessary.

If he be practicing in the country, far from the facilities of the modern hospital, he must be, in addition to all the things heretofore mentioned, a minor surgeon, a skilled obstetrician and gynecologist, an accurate and rapid laboratory worker, a sanitarian, and a man of great physical vitality; possessing enormous internal resources and an insatiable thirst for knowledge, and a love and enthusiasm for his profession which is the guiding power of his life.

Such a man, I submit, is the highest type and representative of our ancient and honorable fraternity, rather than the expert in one organ or set of organs, useful and indispensable though he may be in this year of grace; and there will always be room, and rewards, and the love and honor and respect of men and women and children, for such a man; and his bier will be bedewed with the tears of those who will miss him—the noblest jewels which can ever rest upon the bosom of a man.—*Charlotte Med. Journal.*

ON THE RESULTS OF TREATING EXOPHTHALMIC GOITRE WITH X-RAYS.—Stoney (*British Medical Journal*) speaks very favorably of the results of X-ray treatment of Basedow's disease. She reports the results in 41 cases. Of these, 14 are completely cured; 22 have derived great benefit; only one case did not get well. The improvement is noted in both the subjective and objective phenomena. Stoney gives a small dose (less than enough to turn the Sabourand pastille), about seven to ten minutes, according to the tube. The anode is six inches from the skin. The amount of current used is one half to one milliamperere. In acute cases, treatments are given twice a week for a month. After a fortnight's rest the treatments are resumed. For chronic cases, once a week is sufficient.

VACCINE TREATMENT FOR ACNE.—Galbraith reaches the following conclusions in regard to the vaccine treatment of acne:

The acne bacillus is the cause of acne in all its stages.

The staphylococcus is a surface contamination, and at the most can only aggravate existing pustulation.

Doses of 5 to 10 millions do not suffice to cure, unless one is prepared to go on indefinitely. The doses required range from 20 to 100 millions, according to the type of the disease.

The duration of treatment extends from three to five months in the milder cases, from six to twelve months in the severe forms.

As there is a close relation between the opsonic index and the amount of pustulation, the latter may be taken as the guide to dosage and frequency of administration.

Whilst it is impossible to give anything like a definite prognosis, it may be said that marked improvement is brought about in the great majority of cases and a fair proportion cured, and that it is a striking advance on the older methods of treatment. The mild comedo and superficial pustular types are most amenable to treatment, next the pure comedo type, and last the deep indurated type.

The author states that he has not found an autogenous vaccine give better results than a stock vaccine.—*Practitioner*.

TUBERCLES OF THE CHOROID IN TUBERCULOUS MENINGITIS.—During the past four years there were 128 cases of tuberculous meningitis at the Babies' Hospital, New York City, in only five per cent. of which tubercles of the choroid were found. Because of the great disparity between these figures and the statistics of Carpenter and Stephenson, who reported choroidal lesions in 50 per cent. of their cases, the writer was led to have more frequent examinations of the fundus made in these cases.

Careful and repeated examinations of the fundus in the last thirteen cases revealed choroidal tubercles in each case—that is, the examination was positive in thirteen consecutive cases, giving a percentage of one hundred. In several cases which were examined on successive days, one or more tubercles were found which were not present the day before, and one case, carefully examined and nothing found, four hours later showed a tubercle.

The choroidal lesions were small, miliary tubercles, round or oval in shape, rarely irregular, of a grayish or grayish-white color, and usually



without any pigment, as though the retinal pigment epithelium had been gently brushed away, leaving a so-called "moth-eaten" edge. Retinal vessels are frequently seen traversing the surface of the tubercles. In size the tubercles vary from a speck to a mass the size of the optic papilla or larger. The majority were about one fourth the diameter of the disc, generally situated in the neighborhood of the optic disc or macula. In the greater number of cases they are limited to one eye only. Papillitis was found in four cases. Decemetritis, as in other forms of exudative choroiditis, was not found in cases of tuberculous meningitis with tubercles of the choroid.

The fact that the greater frequency of examination, several times a day, the percentage jumped from 5 to 100, leave little doubt as to the importance of frequent examination.—*Dr. Wilbur B. Marple.—Ophthalmoscope.*

WILLIAM SPENCER, M. D.

A CASE OF ULCERATIVE KERATITIS CAUSED BY THE BACILLUS OF DIPHTHERIA.—The author reports a case of corneal ulcer due to infection with the Klebs-Loeffer bacillus—a laborer, aged sixty-nine years, complained of his left eye having been sore for some weeks past. The eyelids were congested and a moderate amount of puro-mucus discharge was present. There was no trace of adherent membrane. The cornea was ulcerated over the lower third, the surface of the ulcer slightly raised and composed of shining, grayish-yellow, sloughing material, with two or three flecks of what looked like blood clot. The upper part of the cornea was clear, and blood could be seen lying in the anterior chamber. Bacteriologic examination showed the bacillus diphtheria in practically pure culture. The ulcer continued to extend, in spite of local treatment, until fully half the cornea was involved and hypopyon was present.

A subcutaneous injection of 4,000 units of diphtheria anti-toxic serum was given, with immediate improvement. Four days later the cornea showed a well cicatrized leucoma. This case is of interest in that an ulcer of the cornea of highly malignant nature, advancing markedly and rapidly, began to heal at once after a single injection of diphtheric anti-toxin, cicatrizing rapidly, in spite of the age of the patient.—*Dr. Leslie Buchanan.—Ophthalmoscope.*

WILLIAM SPENCER, M. D.

ON SALVARSAN.—Salvarsan was used in two conditions: interstitial keratitis and specific iritis with a gummi or syphilitic papule of the iris. In several cases of interstitial keratitis which showed a markedly positive Wassermann reaction, salvarsan produced no appreciable effect on the condition of the keratitis, except possibly a slight diminution of the photophobia, although the Wassermann reaction was subsequently negative.

Two cases of iritis, also showed a positive Wassermann reaction, with a so-called gummi of the iris in each, were treated with salvarsan. Pain, photophobia, lacrimation and ocular injection, which were intense, abated under local treatment, but in neither case was there any effect in the papule of the iris, which, in one case, involved two thirds of the breadth of the iris in the lower nasal quadrant. Injection of salvarsan was followed by extraordinary disappearances of the papule. The large one was dimin-

ished in size one half in forty-eight hours, and at the end of five or six days had disappeared, leaving a synechia. The conclusion was reached that there was no effect with salvarsan in interstitial keratitis, except possibly diminution of the photophobia, and that specific iritis with nodules, it causes the rapid disappearance of the so-called gummi of the iris.—*Dr. W. B. Marple.—Ophthalmoscope.*

WILLIAM SPENCER, M. D.

ON SALVARSAN IN DISEASES OF THE EYE, WITH PARTICULAR REFERENCE TO ITS USE IN SYMPATHETIC OPHTHALMITIS—Seventeen cases of sympathetic ophthalmitis were treated with intravenous injections of salvarsan. The treatment was based on the fact that in sympathetic disease the differential blood count is of the same type as that found in protozoal infections. The large mononuclear leucocytes are markedly increased, chiefly at the expense of the polymorphonuclear cells.

No cases were entirely cured, except three cases in which the diagnosis, apart from the blood count, was not certain; but in each case the blood count approached the normal and the eye condition was much relieved. The cases treated were of long duration; better results might be expected from earlier cases. Most of the cases gave a negative Wassermann reaction.—*Dr. S. H. Browning.—Ophthalmoscope.*

WILLIAM SPENCER, M. D.

ADHERENT PLACENTA.—Rogoff (Moscow) says we possess no symptoms indicating the loosening of the placenta and so we must depend upon those which point to its extrusion for the uterus. The latter consists in the lengthening of the cord, higher situation of the fundus, flattening of the uterus in its antero-posterior diameter, increased movability of the uterus, the appearance of an elastic swelling above the symphysis, and a depression between the latter and the contraction ring of the uterus. Many authors abroad say that generally we may wait for two hours for the delivery of the placenta, for only after this time can retention be assumed and manual extraction is indicated. Under certain circumstances retention may be diagnosed earlier than this, especially when there is hemorrhage. If a large child or twins have been born, when there is danger of hemorrhage with subsequent atony it is advisable not to wait, but after the lapse of a half hour, to proceed to expression of the placenta. The pathological conditions of the third stage of labor have been divided into irregularities of loosening and of extrusion. After being loosened the placenta may be retained by spasm at the contraction ring or because of atony of the uterus. After the placenta has left the uterus, it may still be retained in the lower portions of the birth canal by reason of insufficient assistance for the abdominal muscles. The irregularities of separation of the placenta may consist in one part or the whole remaining adherent. In some cases the fetal membranes only are adherent, after separating from the placenta proper.

Other conditions which interfere with the normal progress of the third stage of labor are dislocation of the uterus, overdilatation of the bladder, too small or too large placenta, or the placenta lacking resistance as in dead fetus. Improper manipulations of kneading or pressure upon the uterus are believed to be the cause of retention in private cases attended

by midwives. These manipulations when improperly made interfere with the normal contractions and relaxations of the uterus which characterize the third stage, and they produce a tetanic contraction of the uterus which interferes with placental separation. Some recently studied specimens of retained placenta have shown changes in the decidua degenerative and atrophic in character with proliferation of the villi which have penetrated the muscular tissue. The operative manual delivery of the placenta must ever be regarded as a serious intervention, the main danger being sepsis. It is advisable after introducing the hand not to withdraw it until the separation is accomplished. After citing cases and considering minutely other details the author concludes that placental retention is usually due to imperfect management. Although adhesions undoubtedly occur yet they are not present in all cases calling for manual aid. Before intervening with the hand, Creder's method possibly in narcosis should be tried. The mortality after manual delivery is not high, provided infection has been excluded beforehand. Uterine irrigation is called for immediately after operation, and should be repeated on the appearance of foul odor.—*Monatsschr. f. G. w. G.* Vol. 36, p. 175.

THEODORE J. GRAMM, M. D.

**COAGULABILITY OF THE BLOOD DURING PREGNANCY, AND IN ECLAMPSIA.**—Ebeler (Dortmund) has found that in the later months of pregnancy there is a shortening of the time of coagulation, which continues during labor, and gradually lengthens during the puerperal period so that toward the end of the second week has reached the normal time. The coagulability of the blood is normal during the first six months of pregnancy. During menstruation as also during other genital hemorrhages coagulation is delayed, except in post partum hemorrhage and during the last months of pregnancy. Profuse and rapidly occurring hemorrhages usually cause a shortening of the time of coagulation.

The coagulability of the blood has been studied by Engelmann and Ebeler. They say it may be accepted definitely that the time of coagulation is diminished in this disease and usually to a material extent. Consequently every hypothesis concerning the origin and nature of eclampsia must reckon with this fact. The treatment of this disease with iodide of potash, which Sellheim has revived, rests upon the effect of this drug to diminish the viscosity and coagulability of the blood.—*Monatsschr. f. G. w. G.* Vol. 36—189 and 206.

THEODORE J. GRAMM, M. D.

**ENUCLEATION OF UTERINE FIBROIDS.**—Schöpp, of Menge's clinic in Heidelberg, makes a plea for the more frequent enucleation of uterine fibroids whenever possible, in preference to hysterectomy or the supra-vaginal amputation, particularly in younger women. Even in older patients this conservative surgical procedure is often more rational and easier in performance. The mortality is less than that of hysterectomy. Convalescence is usually without incident, and 70 per cent. of his cases were quite well many years after, and several of them had conceived. In two cases the operation was successfully performed upon the gravid uterus.—*Monatsschr. f. G. w. G.* Vol. 36—532.

THEODORE J. GRAMM, M. D.



**LIVER CHANGES IN PREGNANCY.**—Heynemann (Halle) says the frequent appearance of albumin in the urine during pregnancy, in the toxæmias of pregnancy and in eclampsia have led to the idea of the kidney of pregnancy. In the same manner the anatomical changes in the liver in eclampsia and the growing knowledge of the liver as the organ concerned in metabolism have suggested the liver of pregnancy. In Germany it is mainly Hofbauer who has fostered this idea of the liver of pregnancy and the great importance of the liver in the toxæmias of pregnancy. According to him there are anatomical and functional changes induced by pregnancy. The liver is believed to be in a condition of diminished functional capacity so that only by means of its reserve powers it can fulfill the demands made upon it. In hyperemesis he found more serious changes. The well known liver changes in eclampsia he characterizes as acute intra-vital anolysis depending upon a ferment intoxication derived from the placenta. Scheckele, on the other hand, has denied the normal occurrence of liver changes. Heynemann has therefore endeavored to determine whether through the demonstration of metabolic changes we may assume a liver of pregnancy, and whether in the toxæmias of pregnancy the demonstrated anatomical changes can be recognized or diagnosed during life. Omitting all the details, the conclusions reached are that from a chemical standpoint the assumption is not warranted that the healthy liver is damaged by pregnancy or is usually injured in its functional powers. It is true that greater demands are made upon the organism during pregnancy, but these are usually met by increased powers. If the body has been previously damaged these increased demands cannot be met, and then functional and other disturbances will result. But we are not warranted in assuming a liver of pregnancy characterized by typical functional changes. From the examinations made by this author he also concludes that there is no direct connection between the liver and the toxæmias of pregnancy; neither does the liver play an especial role in the origin of eclampsia.—*Zeitschr. f. G. w. G.* Vol. 71—110.

THEODORE J. GRAMM, M. D.

**THE LIVER IN PREGNANCY.**—In concluding another extensive study of the liver during pregnancy, at Viet's clinic in Halle, Landsberg says it is quite obvious that the organism during pregnancy as a whole and in its separate parts functionates quite differently than in the non-pregnant state. This is not surprising. Pregnancy cannot be compared with any physiological or pathological condition. The peculiar conditions demand that the various life processes in the pregnant organism shall be conducted quite differently than we are accustomed to see under normal conditions. The author thinks we are not justified in regarding these differences as defects of function of one or other organ. On the contrary, they indicate that the body is able to cope with changed conditions. It is not thinkable that pregnancy could progress within the physiology of the non-pregnant body. We should strive to grasp the changes in the pregnant body as physiologically necessary, and should never regard them from a pathological standpoint.—*Zeitschr. f. G. w. G.* Vol. 71—163.

THEODORE J. GRAMM, M. D.

## Monthly Retrospect

### OF HOMOEOPATHIC MATERIA MEDICA AND THERAPEUTICS

CONDUCTED BY A. LEIGHT MONROE,

Miami, Florida.

SCILLA.—By Horace P. Holmes, M. D., Sheridan, Wyo.—*Scilla maritima*, or squills, is the common squills of household and old school practice. It is a sea onion found about the Mediterranean. There are two varieties, the white and the red, the latter of which is used in the preparation of our homœopathic remedy. We use it in the form of a tincture.

Scilla was proved by Hahnemann and his associates and but little has been added to its literature by either Allen or Hering in their complete works. The latter author starts his article in Guiding Symptoms with: "Great anxiety of mind, with fear of death," so identical with aconite and arsenicum. This symptom like so many others in our materia medica, may be misleading, as both anxiety and the fear of death may not be present at the same time. As anxiety was a prominent symptom, and fear of death was observed, Stapf put the two together. We may meet with anxiety under this remedy but not necessarily fear of death. The patient is irritable, angry about trifles as in *chamomilla*, with aversion to mental or physical labor, which might make sea onions a good diet for Coxy's army.

The headache of scilla reminds us of *bryonia*. There is headache in the morning on waking, pulsation on raising the head. The child rubs its face and eyes a great deal, which is similar to *cina*. *Cina* rubs and picks at the nose, while scilla it is the face and eyes, as if to relieve the itching.

In the eyes there is a sensation as if swimming in cold water, or sensation of cold water in the eyes when in cold wind. Remedies having a somewhat similar symptom are: *Lachesis* has "cold tears." "Cold feeling in the eyes" is found under *berberis* and *medorrhinum* while *Thuja* has "sensation as if cold air was blowing out through the eyes." "Eyes seem cold," *euphrasia*. "Coldness in eyes," *alumina*, *conium*, *lycopodium* and *platina*. The upper eyelids may be swollen in scilla as in *kali carb*. Elaps has the symptom, "Bloated around the eyes in the morning."

Scilla has an exciting action on the mucous membranes as shown by the symptoms of the whole respiratory tract and the urinary system. There is sneezing, coughing and watery eyes so characteristic of *allium cepa*, *euphrasia* and *pulsatilla*, and in measles. There is an acrid, fluent coryza, worse in the morning. Hering characterizes it as "A regular snizzle," if anyone knows what that means. "Snizzle" is a new word to me, and is probably a misprint for snuffle. This symptom reminds us of one of the other onions, *allium cepa*. The nostrils are painful as if sore, with vio-

lent coryza, as in *allium cepa*, *arsenicum*, *arsenicum iodatum*, *arum*, *mercurius cor.*, etc.

Food tastes bitter, especially bread. *Asarum* has "bread tastes bitter."

There is great irritation, burning and dryness in the throat, like *arsenicum* and *capsicum*. There is an inclination to cough in the throat, in upper part of trachea. There is nausea during morning cough, and nausea in back part of throat. This is probably sympathetic, caused by the irritation and fullness in throat.

Among the stomach symptoms we have "pressure like a stone" characteristic of *arsenicum*, *calcareo carb.*, *graphites*, *nux vomica* and *pulsatilla*.

Stools involuntary when coughing, sneezing or passing urine. *Phosphorus* has involuntary stools when coughing, and this symptom I have repeatedly verified. *Sulphur* has involuntary stool when sneezing. Involuntary stool while urinating is covered by *alanthus*, *aloes*, *muritic acid*, *scilla*, *sulphur* and *veratrum alb.* *Scilla* is the only remedy having all three conditions causing involuntary stools. This symptom, together with the throat symptoms, shows *scilla*'s relaxing effect on the orifices of the body.

The urinary symptoms point to the use of this remedy in certain dropical affections, cystitis, enuresis and diabetes. There is sanguinolent urine with a red deposit, as in *terebinth*, with *tenesmus* after micturition, as in *cantharis*. The frequent calls to urinate at night, passing large quantities of pale urine, recalls *phosphoric acid*. There is violent urging to urinate with large quantities of pale urine, which suggests the remedy for diabetes.

In its action on the kidneys, *Hahnemann* brings forth an illustration of the primary and secondary action of *scilla* which applies to many other remedies—notably *apocynum can.*—and which should be borne in mind by the superficial homœopath. *Scilla* in large doses causes a profuse secretion of urine and was used by the Egyptians in dropsy and with great rejoicing when this large discharge of urine was produced. But the secondary action, which is scanty secretion, soon follows and the disease is really made worse by the remedy. We homœopaths, as well as all other physicians, should realize that a prompt, active diuretic is a bad remedy to give in dropsy due to insufficient urination, for, while the primary action seems to produce the desired result and to indicate intelligent practice, the secondary action, which is opposite, and sure to follow, leaves our patient worse than before. This recalls *Hahnemann*'s early observation, while he was an old school physician, that many of his patients would have done better had he left them.

It is mainly in the respiratory tract that we find the useful sphere of *scilla*. It covers bronchitis, pneumonia, whooping cough and asthma. There is wheezing, rattling and dyspnœa. The patient must sit up. There is shortness of breath on exertion and ascending, as in *arsenicum* and *calcareo carb.* There is dyspnœa so great that the patient cannot drink for want of breath. *Kali nitrate* has the same symptom.

The child grasps the cup greedily, but can only drink a sip at a time for want of breath.

The cough is terrific, and its fierceness, persistency and staying qualities are equalled by few remedies. We find the peculiar symptom: "Spurting of urine when coughing." This is found under but few remedies, notably



alumina, causticum, conium, natrum muriaticum, pulsatilla and veratrum album. The cough is dry at night and loose in the morning. It is more fatiguing when loose than dry, but is tedious at any time. The cough is worse from cold drinks, from exertion and from change from warm to cold air. Silicea has cough worse from cold drinks, while cough worse from change to cold air calls for principally carbo veg., phosphorus, rumex, scilla and veratrum album.

Scilla is indicated in the cough of measles and also by the skin symptoms of that disease.

Every fit of coughing winds up with sneezing and involuntary urination. I have several times verified this symptom. The sputum is white or reddish mucus. It may be sweetish and offensive, as in calcarea carb., and stannum. It may be in small round balls, very difficult to expectorate. Drinking cold water brings on the cough. Lycopodium has cough aggravated by drinking cold water, silicea cough excited by cold drinks, causticum has cough relieved by drinking cold water.

The chest and lung symptoms are most similar to those of bryonia. There are stitches in the chest, stitches under the last ribs, stitches on inspiration, stitches under scapula, and severe stitches under sternum—so severe as to make it difficult to draw a breath. Bryonia and kali carb. are probably the nearest related to scilla in stitches in the chest. There is profuse secretion of tenacious white mucus, expectorated only after severe coughing. Hering gives the indication, once very valuable but now obsolete: "Especially suitable in pneumonia and pleurisy after blood letting."

One must not forget that the arguments regarding the action of scilla in dropsical affections, when given in appreciable doses, apply also to lung and bronchial troubles. Large doses of squills increase the mucus secretion and thereby make expectoration easier. This is the primary action. But the secondary, opposite action follows, and if the trouble is long-lasting, or with a chronic tendency, the mucus becomes tougher and the cough dryer.

There is convulsive twitching in the limbs, both in arms and legs, worse mornings and from motion. There are cold hands and feet and cold foot sweat. Rheumatic pains which are worse during motion. The limb symptoms remind us of bryonia and calcarea carb. "Icy cold hands and feet, with warmth of the rest of the body," is a symptom found in such words only under scilla and menyanthes. Icy cold feet calls principally for cedron, elaps, phosphorus, scilla, silicea and veratrum album. Sweat only on toes, scilla. Sweat under toes, taraxacum.

In fever there is aversion to being uncovered. When he uncovers during fever he suffers from chilliness and pains, as in nux vomica.

Scilla is not only compatible after bryonia, but it is a very close analogue of that remedy. It has its opposite symptom in cough, as bryonia is worse in change from cold air. In the furious, exhausting cough we would compare it with corallium, cuprum and stannum.—*Homœopathic Recorder*.

THE PRESENT STATE OF OUR KNOWLEDGE CONCERNING HAY FEVER.—By W. P. Dunbar, Hamburg (*Annals of O. R. and L.*, June, 1912).—Hay fever is a disease caused by toxic substances found in the dust of the blossoms of certain plants. They are present in albumen of the pollen and are specific in nature. It is possible to produce a specific antitoxin by inoculating

animals with the albumen of the pollen. John Bostock in 1819 accurately described the European type. Patient first had occasional itching at the inner canthus of the eye. It may appear again and again, caruncle gets red and mild and infrequent sneezing occurs. Paroxysmal attacks come on at any time. The eyes itch fiercely, conjunctiva very red and edematous, nose blocked, mouth and especially the gums itch. Then comes malaise and general weakness and depression. Asthmatic symptoms occasionally appear. Some have an unbearable itching of the skin. All symptoms may disappear for several days only to reappear. This lasts for six weeks and gradually disappears. The patient feels feverish but there is never any elevation of temperature. The following year it returns punctually.

*Etiology.*—The cause has been laid at the door of many things such as, nervousness, imagination, moist heat, dazzling light, dust, bacteria, delicate odors from plants, cats, mice, dogs, horses. With regard to the animals there may be a definite chemical substance in their hair which causes a condition like hay fever. However pollen antitoxin has been known to stop the symptoms.

*Authors' Experiments.*—The author is a hay fever subject himself. The pollen was collected by shaking blooming plants. A minimal amount of plant dust put in conjunctival sac or nasal passages quickly caused hay fever. The same thing on non-hay fever patients had no effect. All hay fever patients were affected but no others. Pollen dried soon after gathering would produce hay fever at any time of the year. If kept fresh it liquified and was harmless. Many pollen grains are covered with hair-like prickles, but the pollen which most often causes hay fever is smooth. This is true of thirty-two varieties of grass pollen and they all have rod forms like bacteria which are starch and are harmless. The active principle of the toxin of hay fever is an albumen. The alcohol precipitate from a saline extract of a comparatively small number of pollen grains has an intense action on hay fever patients, but none on normal individuals.

Liefmann showed that there is no pollen in the air on rainy days and the average daily number gradually lessened during July and early August. Grass pollen is 40 per cent. albumen and 20,000,000 rye pollen weigh one gram. Standard solutions can thus be used and it was found that different patients were susceptible in varying degrees. A concentrated solution has no effect on a normal patient but one drop of 1-20,000 solution stimulated hay fever patients and even 1-100,000 affected some.

#### HAY FEVER II.

Chrysanthemum and the other asters. Those who have the spring catarrh react to the grasses and not to the golden rod and ragweed. Hay fever requires an individual predisposition. Antibodies are found in the blood of hay fever patients near the end of the season but not at all in normal individuals.

Hay fever has no relation to constitutional diseases like gout. Stopping up of air passages does not cause it. A local disease of the trigeminus or other cranial nerves causing sensitiveness of certain mucous membranes does not hold true, because the anal mucus membrane reacts to pollen toxins. Suggestion, as a cause, has many follow-

ers but experiment with pollen toxin proves there is no truth in it. Men appear twice as susceptible as women. Anaphylaxis is used by some to explain the susceptibility of certain patients but it is not clear yet. It differs in this respect, that the blood of hay fever patients injected into guinea-pigs and twenty-four hours later injecting the albumen of pollen does not cause anaphylactic symptoms. A patient is not antianaphylactic after an attack of hay fever. There is a hay fever predisposition but it does not appear to be anaphylactic. One of my coworkers used pollen toxin experimentally more than a thousand times with no change in his susceptibility. It differs in a third way, for it is possible by means of the pollen albumen to produce a real antitoxin. Also, normal individuals are not rendered susceptible to hay fever toxin by subcutaneous injections of pollen albumen. The blood of hay fever patients after the period has hemolytic power on guinea pigs, rabbits and sheep and six months later the power is nearly all gone and only corpuscle agglutination left.

*Diagnosis.*—Hay fever patients react with 1-200,000 solution of pollen albumen while normal patients do not react to a one per cent. solution. This makes the diagnosis easy, also we can tell whether it is European hay fever or American autumnal catarrh. It eliminates pseudo-conditions.

Many rabbits and some horses are especially adapted for the production of an antitoxin by injecting pollen toxin. To test the activity of a serum neither the precipitin reaction nor the compliment deviation test can be used. The action of the toxin is purely local. If put in one eye it does not spread to the other. The author is convinced that pollen toxin and antitoxin belong to the class of true toxins and antitoxins like diphtheria.

*Treatment.*—Nasal operations are absolutely useless. There are only three successful ways of treating it. (1) To remove to a locality where the specific cause does not occur. (2) To protect eyes, nose and mouth from the pollen. (3) To use a specific antitoxin. An active immunity cannot be brought about. Injection of horse serum antitoxin is apt to cause anaphylaxis. Pollatin as a powder is now on the market. Apply to mucous surfaces of the eye, nose and mouth before any symptoms have begun. Inflamed surfaces do not absorb the antitoxin.

#### HAY FEVER III.

Subcutaneous injections at best last only a few days and we run the danger of serum anaphylaxis. Use only small quantities locally for anaphylaxis has been caused in local applications. We cannot get rid of the irritating contents of horse serum because the anaphylactic agent is bound to the euglobin as is also the antitoxin, itself. Treat anaphylactic patients by using a newer preparation, pollatin R. before the attack begins, in small doses and only once a day. Patients who have become anaphylactic get along with smaller doses and are more apt to overcome the hay fever disposition than other patients. The ideal treatment is to combine the active and passive immunization treatment.—*New York Post-Graduate.*



# THE HAHNEMANNIAN MONTHLY.

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THE PROGRESSIVE MODERN HOMŒOPATHIC PRACTITIONER THE PRO-  
TOTYPE OF THE MEDICAL PRACTITIONER OF THE FUTURE.

BY

ELDRIDGE C. PRICE, M. D., BALTIMORE, MD.

(Read before the Homœopathic Medical Society of the County of Philadelphia,  
April 10, 1913.)

THE metamorphosis of the typical "allopath" of to-day into the typical medical practitioner of the future, will not be sudden.

As the world grows—according to the signs now obvious—the thoroughly trained medical practitioner will gradually adopt all methods of healing that are really practical and good, and as homœopathy is certainly practical and good his education will necessarily include the advantages of a practical working knowledge of the principle of similars.

While it seems to be a fact that the best in medicine, regardless of pathy, is being taught in a number of our homœopathic colleges, yet it is questionable whether these colleges are taking a position best qualified to attract students to this modern breadth of medical thought and practice. Some of the older school colleges follow quite a broad and liberal curriculum, but, I have heard, there are some so far in the rear of progress that they still do not hesitate to speak disparagingly of homœopathy. Of course, these latter are not the institutions from which the typical physician of the future will be evolved.

Science is too broad, too universal to omit anything which contains truth; and because in a short period of time our views do not seem to progress in the direction of universal acceptance, is no reason to think this acceptance may not be realized at some time in the future. Furthermore, it is not reasonable

to expect the acceptance of homœopathy, even ultimately, in all its minutiae and manifold details prescribed by Hahnemann. If during the one hundred years of its presence in the world of thought, when therapeutics was but a method of unsystematized guess-work, we have failed to convert the general medical world to a belief in homœopathy as homœopathy, when during that time many of our colleges, books, and magazines preached the Hahnemannian creed in its purity, then it is not reasonable to expect a much wiser medical world to accept views which even many of the most prominent of our school have begun to question.

I refer to such tenets in the Hahnemannian system as the totality of symptoms, the olfaction of dilutions, the condemnation of anodynes, the absolute *proscription* of alternation of drugs, the insistence upon the idea of a diseased vital force as a basis for pathology, etc., etc. The insistence upon the acceptance of these ideas has been a positive bar to the spread of homœopathy, to the acceptance of the fundamental truth of the law of similars.

The practitioner of medicine is in search of means for healing the sick, and if he is not simply a metaphysician then he will accept those means which will bring about the results for which he is in search. These means may sometimes be found in the field of surgery, in the field of the sera, the toxins and the anti-toxins, or in the field of what is regarded as orthodox *materia medica*.

The point may be raised, that our progressive colleges teach all these things *and* homœopathy—or vice versa, if you please,—but for all that the number of our students is gradually diminishing.

What does this mean? It means that as a distinct school, our days are numbered.

We may resent the idea, and struggle against the great current of evolution all we choose, but we can not stem its resistless power. Even were our colleges all heavily endowed, the ultimate result would be retarded but little.

Why is it? Why, with all the zealous attempts to bring the great truth of homœopathy home to the medical world, both in the making and in the matured scholastic product, why have our efforts not succeeded?

We have failed because we have worked to secure conformity to form, and in securing conviction to the central truth have

exacted compliance in things not essential. It is in the unessentials we have failed, while at the same time we do not realize that in the really essential we have succeeded overwhelmingly, and have not yet awakened to the fact of the stupendousness of the success. It is not the first time, however, that the greatest victories have been born of supposed failures.

I have said *we* have succeeded, but it is more modest, it is more consistent with fact, to say that the great principle of truth, which is the *vis a tergo* of all vital evolution, has forced the workers in the vast fields of scientific endeavor to conclusions which are becoming gradually more and more obvious to the thinking world, that the many phenomena which have been observed in the great field of modern pathogenetic and therapeutic experimentation—orthodox though they be—are explainable through an understanding of the law of similars.

The fear some seem to feel, that the future of homœopathy depends upon whether or not the homœopathic school conducts exhaustive investigations and experiments for the purpose of establishing the legitimate place of homœopathy in the world of science, is gratuitous. The place of homœopathy as a scientific system of medicine is already firmly established through the exhaustive work of practical scientists—notably, Pasteur, Koch, Calmette, Wright, Simon Flexner, etc., etc.—and will without doubt be still further demonstrated by future similar work.

Possibly the *name* homœopathy may be lost in the effort to demonstrate the *principle* to be but a part of the results of the great evolution of modern vital science; but I am by no means sure—after the smoke of the great battle of the medical schools shall have blown over—that even the original name may not be accorded its merited restitution.

The experimental results in the field of general medical research have been given no definite classification in relation to pathogenesy or therapeutics. They have simply been submitted to the medical profession for further experimentation to establish their practical value. Hence, we find the various toxins, nosodes, and sera generally, being applied throughout the world.

As to the relationship existing between their pathogenetic power and their therapeutic power, nothing is said. Whether this relationship is antipathic, allopathic or homœopathic, does not concern these experimenters at this time; they are simply



searching for practical results, and agents with which to work practical results, and care nothing whatever for hypothesis, theory, or even *modus operandi* of therapeutic application.

The homœopathic profession has devoted a whole century to the practicing and preaching of homœopathy, and but a small number of all concerned—both of the medical literati and of the laity—has been brought to a realization of the truth. It apparently remains to the hereditary revilers of Hahnemann to reveal to the world the verity of homœopathy.

Here is a remarkable situation, a situation in which we find the friends of a named truth retarding its general acceptance, while the enemies of this truth are zealously proclaiming it and at the same time denying its name.

From this we feel justified in suspecting that there must be something deterrent either in the manner in which propagandistic effort to spread homœopathy has been made, or that something in the teachings themselves is repellent.

To some, the idea of endeavoring to preach scientific facts after the manner of theological proselytism, is not in accordance with the methods of the thorough acquisition of great truths, the necessities of science; to say nothing of the question of the dignity of such a proceeding on the part of a body of scientists. And the desultory, and in many instances the illiterate manner of teaching homœopathy, bound together with all the various unessential views which have unfortunately been connected with it in the past, has not helped the cause, excepting retrogressively.

Some of us still remember the box-and-book doctor. The box of half- or quarter-drachm vials containing nothing lower than the 30th centesimal "potencies," and the book to tell the practitioner how to prescribe them. Many of these practitioners had never seen the inside of a college; they knew no more of anatomy than a present day Christian Scientist; of physiology they knew but little; of pathology nothing, and still less of diagnosis. The box and book embodied their full equipment, and, strange as it may seem, they made some wonderful cures. This means several things: one is, the powerful effect of psychic suggestion; another is, the possibility that the directions in the book were sometimes correctly interpreted, and still another is, that seven-tenths of all subjective conditions are constantly changing and disappearing spontaneously.

In these early days quacks were quite impartially distributed

through all schools of medicine; the homœopathic school contained no more in proportion to its numerical importance than did the "allopathic" school; but unfortunately the methods of the quack were taken by a large class of the laity as representing the methods of legitimate medicine. Consequently, when the illiterate, unqualified practitioner of homœopathy appeared in a community he was accepted as a fair exponent of the system. Homœopathy thus received a most unfortunate introduction to the lay world; and in many communities the local profession was hopelessly prejudiced by this kind of advent.

Is it remarkable, therefore, that it has remained for the work of the thorough, impartial experimenter to introduce and establish the truth of homœopathy through the methods of correct, demonstrable knowledge?

After carefully considering the ideas suggested, it becomes obvious that the homœopathic profession must find its own through the proven and trustworthy methods of scientific procedure, and not through illy considered dogmatism.

In this remarkable stage of the evolution of the law of similars towards its goal of universal acceptance, we find the modern progressive homœopathic practitioner the essential connecting link between the old line symptomatologist and the modern homœopathically unbelieving scientist. This man not only *should* have, but as a matter of fact *does* have, the education of the "allopath" plus a knowledge of theoretical and practical homœopathy. He is the peer of any well educated practitioner.

This is the kind of man we know Hahnemann to have been. We know that he was the kind of man who investigated all things medical, and held fast to that which was good. Of course, being human, he had his shortcomings, and being of a positive, dominant character he naturally became more or less dogmatic as years wore on; but with all his dogmatism, in the prime of life he was a fair-minded investigator, and when he was convinced of the utility of a fact he was wise enough to profit by it. This is proven in the history of his experiments with cinchona. Having through investigation and practical experiment, demonstrated the relationship between cause and effect in the pathogenesis and therapeutics of this drug, he proceeded to weigh similar evidence in relation to other drugs; and thus, through the keen fairness of his mental processes he laid the foundation of the system which has so stirred the medical world.

An idea to which attention may here be called, is, that while the law of similars is now what it has always been and will always be, yet it is by no means certain that a belief in this law will always imply also a belief in some of the collateral Hahnemannian hypotheses which his disciples considered essential in his day. While Hahnemann was unqualifiedly a great man, and was intellectually and educationally superior to both his critics and his cotemporary disciples, yet, as has many times been said, Hahnemann was finite, and much of the knowledge of to-day was far beyond the possibilities of the imagination of a century ago.

There are some who always seem to be afraid of doing something, or believing something, of which Hahnemann would not approve. Is it not quite as reasonable to reverse the situation, and in the light of modern information question whether or not we can reasonably approve of all the views and practices of the great reformer? For example, his expressed preference for the use of drugs by olfaction. In the note to Sec. 288, Hering's 1848 edition of the *Organon*, Hahnemann says of this method: "All that is curable by homœopathy may with the most certainty and safety be cured by this method of receiving medicine."

Hahnemann was a great man, and his character was strong, but nevertheless he was not infallible. His pre-vision was wonderful, but it was subject to human limitations. He inculcated a great truth, but it was impossible for him to know that within two generations after his death bacteriology would reveal facts no human being could predict, that the microscope would make common knowledge of that which no man could possibly imagine, or that the evolution of science would develop such wonderful therapeutic resources in that awe inspiring form of energy we call electricity. Is it possible Hahnemann would have turned a deaf ear and a heedless eye to these things and declared them of no value from the standpoint of the real healer of the sick? Would he have endeavored to prove all the cures due to the destruction of germs and toxins in the blood current by anti-toxins—which have little effect upon the human organism—as based upon the law of similars, and that none of the wonderful cures made in the field of electro-therapeutics could be accepted as worthy of consideration unless homœopathy be the sanative principle involved?

We can not believe our German Hippocrates would have as-



sumed such an attitude. Our faith in his greatness compels the belief that such an attitude would have been un-Hahnemannian; it certainly would have been unscientific, and Hahnemann's mind was pre-eminently of scientific mould, else he could not have gathered together the loose ends of thought thrown from the workshops of his worthy predecessors and formulated them into a definite therapeutic system.

If, therefore, it is reasonable to believe that the founder of homœopathy would have welcomed such aids to the great work of healing mankind, why should not his followers take the position of thinkers and act for the greatest good to the patient, trying those means which offer reasonable promise of efficient aid, whether cures resulting from such means be explainable by one of nature's laws or another?

Hahnemann says: "The first and *sole* duty of the physician is, to restore health to the sick." Later in his rare classic he proceeds to tell what he believes to be the best way to secure such an end. It is just because of this explanation—or series of explanations—that physicians have floundered in bogs of speculation, and often seem to have lost sight of the profound truth embedded in the primary postulate with which the great teacher begins his discourse. Our sole duty, our paramount duty is to heal the sick.

After eliminating the thousand-and-one learned and unlearned "reveries" with which the medical profession was cursed in Hahnemann's day, and from which *ex cathedra* authority was found by the regnant profession for forcing into human bodies of which they knew little massive doses of drugs of which they knew less—or *vice versa*, if you please—and putting into the place of this chaotic state of therapeutic knowledge such means for healing the sick as are now in use, is it possible that the believer in homœopathy can find nothing that he can consistently use besides that which has been demonstrated to be homœopathic? Is it possible that during the past hundred years no mind has evolved any means for healing the sick that would meet with the approbation of the great Hahnemann? As the human race grows and develops, making all kinds of discoveries and inventions, is it possible Hahnemann still towers over the whole great world of mind, no peer of his greatness having yet been born worthy to stand shoulder to shoulder with this giant of the past?

This is hardly reasonable, and if such an idea is unanimously

and continuously entertained by our school are the probabilities of its progress, or even of the continuance of its very existence, encouraging?

What then should be the attitude, both theoretical and practical of the believers in homœopathy at the present time?

This attitude may be expressed through a number of different instruments, and both the secular world and the general medical world are influenced by these instruments to the extent of acknowledgment of the right of homœopathy to the recognition and respect of mankind, or the universal repudiation of the claims to such a position.

Individual physicians, medical societies, medical magazines, and medical colleges, are the instruments whose attitudes individually and collectively give the world at large the right of final judgment of our case.

Individual physicians exert more or less direct influence, depending upon the prominence they have attained in the public mind.

Medical societies supposedly wield a still wider influence; their transactions being regarded by the world as authoritative, and by their avowals of belief or disbelief the world adopts conclusions as to the scientific status of the cause represented by the organization, and the ethical and professional status of the individual constituents, and ultimately forms conclusions relative to the character and importance of the school represented by the given organization.

Our medical journals submit reports of transactions, of usual and unusual cases, of new discoveries and theories tried and untried, and of happenings in the medical and surgical world generally; and through the editorial department have more or less influence in moulding the opinions of their readers, the medical profession, by which in turn the world at large is reached.

Finally, our medical colleges, those formative institutions where doctors are made and elementary beliefs are formed, and from which the medical profession is recruited.

The future of homœopathy as a distinct and separate school of medicine, therefore, depends upon these four great agencies, and the necessity for their harmony and consistency of attitude. In other words, the school of homœopathy has for years been, and is still on trial for its life. It is a jury trial, the people are the jury, the unhomœopathic medical profession represents the

prosecution. The evidence is not yet all in, and there is still time to establish our right to exist as a separate school of medicine yet a little longer, but to do this we must agree upon some definite line of conduct, some attitude towards what the people, or jury, regard as the general medical profession. It will not do to continue quibbling over non-essential hypotheses and theories, to make fighting points of high or low potency opinions, to split over vaccination and anti-vaccination, to damn the alternator, or ostracise the man who uses only crude drugs or nothing lower than the em dynamization. All these things which are unessential to our existence as a distinct school of medicine, must be put aside; not one of them must be regarded as of vital importance either by the individual or by any organization of individuals within the pale of our school. Most decidedly should our colleges be careful to inculcate the essentials and omit the fighting points.

The essentials are obviously those things which pertain to the duty of the physician. The physicians in the making should be taught that the paramount duty of the physician is to heal the sick, and for this end to use the agents that will cure the patient in the quickest, safest, and most certain manner; that in some instances this will be accomplished by surgery and in some instances by medicine; in some instances the principle of similars will be indicated and in others antipathy may be laid under contribution, or even allopathy may be called to aid nature, to say nothing of all other modern means of healing. Let the student be taught the fundamental meaning of homœopathy, of antipathy, of allopathy. Give him this groundwork, and show him when and where he should discriminate in the practical application of this knowledge, and having taught him this, teach him further that in his work of healing the sick he is to do that which in his judgment is for the best good of his patient.

Having thus educated the future practitioner of medicine, not only his beliefs but his practice will differentiate him from the unhomœopathic profession, in that he has been taught homœopathy both theoretically and practically, and all things else necessary to the fully equipped physician. Such is the type of a properly educated homœopathic practitioner, and upon him we must depend for a maximum longevity of our school.

To produce such a thoroughly educated, liberal school of homœopathic practitioners does not mean that the millennium



must arrive, but it does mean that our college faculties must be composed of earnest, thoughtful, liberal, sincere thinkers, who feel keenly the responsibility they have assumed in endeavoring to produce practical, honest, scientific physicians who will be prepared to practice homœopathy intelligently, because they will be qualified to know when it is *not* indicated just as they will be qualified to know when it *is* indicated.

This view of the situation leads us to the conclusion that even more than the medical society or the medical magazine, is the college responsible for the future of the homœopathic school; and next in sequential order of responsibility come the individuals from which is formed organized bodies and by which our journals are controlled. It is to the individual believer in homœopathy that we must look for the continuance of our school as a distinct body for yet a little longer.

I am of the opinion that the time has not yet come when we can wisely immerse ourselves in the great ocean of orthodox medicine, which has from time to time been placed at our disposal by the American Medical Association, in which to drown ourselves. The day will undoubtedly come when, as stated, there will no longer be a distinct school of homœopathy, but that day has not yet arrived. We are not prepared for it, nor is the "allopathic" school prepared for it. Neither school is yet sufficiently liberal, nor in fact, sufficiently well educated for this ultimate state of the medical profession.

That general scientific progress is hastening the great day, is undoubted, but, as suggested, the proper collegiate education of the homœopathic student is a prime factor in this unification problem.

When the general medical profession has been evolved into this rational position of acceptance of the believer in homœopathy, conceding his right of belief and action, and the individual homœopathic practitioner, "the man behind the gun," has been educated up to the point where he is prepared for this profound change, there will be little difference in the views and practices of the men who will then typify what are now two distinct schools of medicine. In fact a single type may then be taken as a fair representative of this unified and liberal medical profession. He will be guided by the requirements and demands of science, which means that he will be open to conviction in all directions; he will not scoff at nor ridicule the views of those with whom he does not agree; he will not be an ex-

tremist nor an exclusivist of any kind, but will hold fast to the old things that are good, and lay hold of the new things that give promise of virtue; and while believing sincerely in the law of similars—though possibly not then so-called—and its practicability, and while applying this law to the best of his ability, he will accept all means for his ends that will be ultimately helpful to his patient—even though he may not be able to explain the *modus operandi* of the agent—and finally, he will always remember that he is not practicing medicine to prove a theory, but to heal the sick.

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### SURGICAL EMERGENCIES.

BY

E. WELLES KELLOGG, M. D.

(Read before the "Helmuth Club," March 4th, 1913.)

I DESIRE to present for your consideration a short history of several cases which have come under my personal care at three different hospitals and which I have classified as surgical emergencies because I consider that they demanded, not only prompt, but accurate and up-to-date technique in their treatment.

When you consider that I am only reporting a small part of the cases which came to me during an actual nine months' service, you will realize the vast amount of surgical emergencies that are being successfully treated all the time.

For brevity's sake, I take it for granted that you are all familiar with the general symptoms and post-operative treatment in such cases, consequently, I shall mention the chief details only.

CASE I.—Mr. P. V.; age 30 years; bartender; admitted to Volunteer Hospital Sept. 29th, 1909, at 11 P. M. Gunshot wound over the ninth rib near costal attachment. No symptoms. Refused operation. At 11.30 P. M. went into collapse, put on operating table at 12. Gall bladder incision. Abdomen full of blood. Penetration of the right lobe of liver. Perforation of loop of ascending colon and bullet lodged near the tip of the 12th rib. Liver wound packed with adrenalin 1-1000 to stop bleeding. Perforation closed by catgut Lembert's suture.

Hot saline irrigation of abdominal cavity. Abdomen drained through incision made for removal of bullet. Primary incision closed. Fecal fistula on sixth day, either due to puncture of intestine by probe in dressing, failure of catgut to hold or undiscovered perforation. Irrigated twice a day with saline. Discharged cured in thirty days.

CASE 2.—Mr. W. S.; age 28 years; Japanese butler; admitted to Volunteer Hospital Jan. 23d, 1910, at 11 P. M. Gunshot wound, middle abdomen. Complete collapse. Taken to operating room at once. Laparotomy. Abdomen full of blood and small worm-like particles, which later proved to be vermicelli or rice sticks. While closing fifth perforation, patient died on the table. Continued search, and found three large perforations in the small and two in the large intestine. Bullet not found.

CASE 3.—Mr. G. M.; age 27 years; press feeder. Admitted to the Volunteer Hospital April 15th, 1910, at 10 A. M. Collapse with distension, vomiting, and intense pain on right side. Diagnosis: ruptured suppurative appendicitis. Taken to operating room at once. Right rectus incision. Appendix normal, but removed. Perforation of tubercular ulcer in the ileocaecal region with escape of intestinal contents and small hemorrhage. Several tubercles in peritoneum and mesentery. Perforation closed by Lembert's suture. Hot saline irrigation of abdominal cavity. Incision closed. Discharged cured in eighteen days.

CASE 4.—Master J. P.; age 16 years; student. Admitted to Flower Hospital May 13th, 1911, at 7.30 P. M. History of being knocked down and run over by large auto. At 8 P. M. symptoms of collapse, with distended abdomen, and passage of bloody urine. Taken to operating room at 9 P. M. Laparotomy. Abdomen and bladder full of blood clots. Rupture of bladder at base and fracture of the pelvis, descending ramus of the pubes. Abdomen and bladder irrigated with hot saline. External urethrotomy opening made. Large drainage tube inserted into base of bladder. Bladder wall sutured together and abdomen closed. Treated as case of external urethrotomy. Pelvic fracture held by a tight corset binder. Discharged cured in 56 days.

CASE 5.—Mr. T. M.; age 28 years; laborer. Admitted to Flower Hospital May 27th, 1911, 9.20 P. M. Gunshot wound right hypochondriac region. No marked symptoms. Taken



to operating room at 10.30. Incision over bullet entrance. Very little bleeding. Three perforations of the small intestine, and two perforations of the mesentery. Bullet found lodged between the folds of the mesentery, close to spinal attachment. Perforation closed by Lembert's suture, hot saline irrigation of abdominal cavity, abdomen closed, slight suppuration of upper wound, due to bullet contamination. Discharged cured in 25 days.

CASE 6.—Mr. J. K.; age 18 years; gangster. Admitted to Flower Hospital Nov. 18th, 1911, at 12.30 A. M. Gunshot wound, left abdomen, state of collapse, taken to operating room at once, laparotomy, abdomen full of blood, eight perforations of small intestine and two perforations of the mesentery. Closed by Lembert's suture. Bullet not found. Hot saline irrigation of abdominal cavity. Slight fecal fistula on sixth day. Saline irrigation twice a day. Discharged cured in 35 days.

CASE 7.—Mr. I. C.; age 73 years; janitor. Admitted to Flower Hospital March 17th, 1912, at 5 P. M. Collapse, Penetrating gunshot wound. Entrance to left of umbilicus and exit through ilium of left pelvis. Unavoidable delay in operation. Laparotomy. Abdomen full of blood and active hemorrhage. Two large perforations of sigmoid flexure. Lembert suture, hot saline irrigation of abdominal cavity, abdomen closed, patient rallied, conscious, finally died next morning at 6 A. M.

CASE 8.—Mr. O. S.; age 35 years; street cleaner. Admitted to Flower Hospital March 17th, 1912, at 5 P. M. Penetrating gunshot wound of the abdomen. Entrance on the right and exit on the left of the umbilicus, due to a fat, protruding abdomen. No symptoms. Later, slight symptoms of distension and hemorrhage. Taken to operating room. Laparotomy. Two perforations of the transverse colon. Entrance and exit three inches apart. Closed by Lembert's suture. Hot saline irrigations of abdominal cavity. Peritonitis and suppuration of bullet wounds. Wounds healed and patient out of bed in 45 days. Also gunshot wound left shoulder, fracturing outer clavicle. Bullet removed under local anesthesia. Held as prisoner until trial. Discharged cured in 73 days.

CASE 9.—Mr. O. M.; age 20 years; gangster. Admitted to Flower Hospital Nov. 6th, 1912, at 1 A. M. Collapse. Gunshot wound of abdomen. Taken to operating room at once.

Laparotomy. Abdomen full of blood. Three perforations in small and two in large intestines and three perforations of mesentery. Lembert's suture. Bullet not found. Hot saline ir-



Case No. 11. Miss A. C. X-ray shows unilateral fracture of pelvis. Taken day after admission



Case No. 11. Miss A. C. X-ray shows result of 8 weeks treatment. Taken 9 weeks after admission.

rigation of abdominal cavity, abdomen closed, peritonitis and broncho-pneumonia. Discharged cured in 30 days.

CASE 10.—Mr. B. F.; age 27 years; gangster. Perfect physique and muscular development. Admitted to Flower Hospital Nov. 7th, 1912, at 3.30 P. M. Walked from ambulance into ward, and undressed himself without aid or symptoms of distress. Gunshot wound, right posterior lumbar re-

gion. No symptoms except slight paralysis and tingling sensation in right leg. An hour later, a feeling of weight in the bladder, with passage of bloody urine and beginning shock. Taken to operating room at once. Laparotomy. Abdomen partly filled with blood, and bloody infiltration of all tissues on the right side, but no perforation of intestines found. Bladder distended, opened, full of blood clots and active hemorrhage from base. Examinations showed good sized tear at base, but impossible to find bleeding point. Bladder packed tightly around large drainage tube. Hemorrhage apparently controlled. Bullet not found. Hot saline irrigation of abdominal cavity, abdomen closed, patient rallied, conscious. At 4 A. M. next morning said that he felt fine, died suddenly at 4.30 A. M.

CASE 11—(*Illustrated*).—Miss A. C.; age 24 years. Admitted to Flower Hospital Nov. 7th, 1912. Knocked down by auto truck. Brought into hospital in state of complete shock. Diagnosis: Severe contusions of back, buttocks, thighs, legs, and left arm; fracture of both bones left ankle; unilateral fracture of pelvis, involving the left, descending ramus of the pubes and ascending ramus of ischium, destroying the continuity of the obturator foramen and the pelvic outlet; compression of spinal cord with hemorrhage, partial paralysis of legs and bladder, incontinence.

Taking into consideration the nervous state of the patient, with the diagnosis and resulting symptoms, together with a painful menstruation, the probable formation of bed sores, and the necessity of keeping her as quiet as possible, you can readily see the difficulty in following out this treatment: Air cushion mattress on a fracture board; a snug corset binder to the pelvis, head of the bed elevated, so as to throw the body forward and downward. Plaster paris cast to left leg, traction made upon left leg by pulley attached to head of bed, so as to force left hip back into position. Treatment continued for eight weeks. Out of bed with massage and walking with crutches. Discharged, cured in 73 days.

CASE 12—(*Illustrated*).—Cecelia La V.; age 6 years. Admitted to the Laura Franklin Hospital Dec. 15th, 1912. History of a fall: Supra-condyloid fracture of the left humerus with dislocation of distal fragment. Apparently proper reduction, but disproved by X-ray. Considerable swelling, echymosis and bleb formation about joint. Waited twelve days before operation. Fragments approximated with chromic catgut





Case No. 12, C. La V. X-ray shows supra-condyloid fracture of humerus. Taken 2nd day after admission.



Case No. 12, C. La V. X-ray shows result of suturing fragments. Taken 3 weeks after operation.

through drill holes. Discharged, cured in 46 days after operation with almost perfect function.

CASE 13.—Mr. C. M.; age 20 years; gangster. Admitted to Flower Hospital Dec. 28th, 1912. Painful distension with symptoms of vomiting, obstruction and collapse. Diagnosis: Intestinal obstruction from previous operation (see Case No.

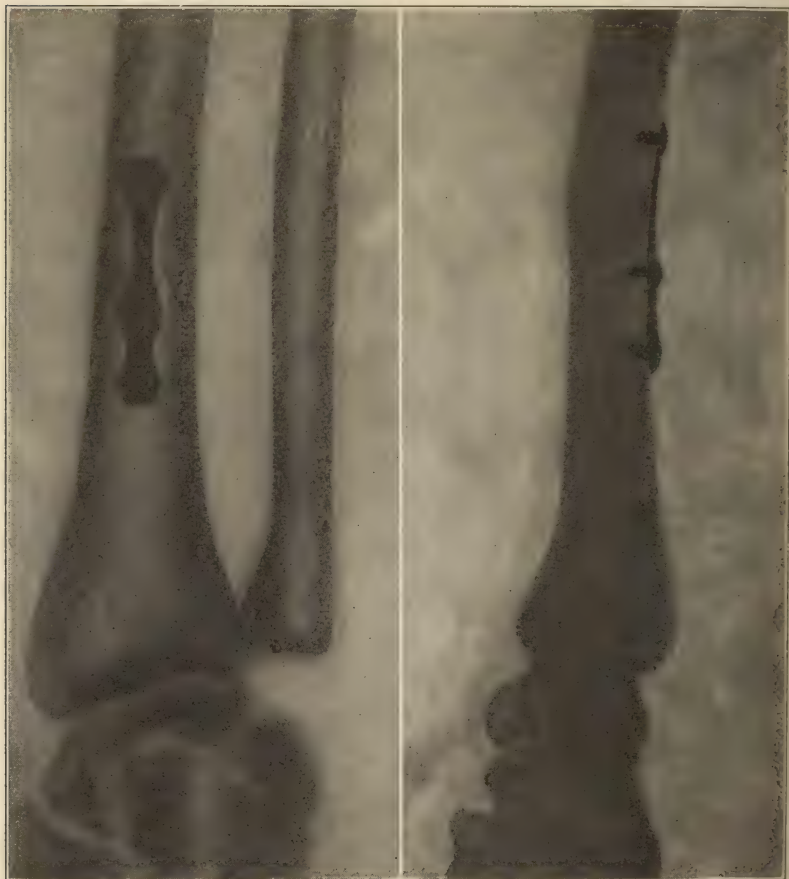


Case No. 14. Mr. E. R. P. X-ray shows perfect reduction by aid of Vanadium steel plate. Anti-posterior and lateral views. Taken 7 days after operation.

9). Laparotomy. Hernia of the intestine. Several intestinal adhesions, binding the intestine to the old scar, between which, large intestine had slipped and become strangulated, almost gangrenous. All obstruction removed. No signs of former intestinal sutures. Hot saline irrigation of abdominal cavity.

Abdominal cavity wiped dry. Abdomen filled with one per cent. oleum telesphoros and camphor solution. Abdomen closed, no complications. Discharged, cured in 17 days.

CASE 14—(*Illustrated*).—Mr. E. R. P.; age 23. Admitted to Flower Hospital Jan. 4th, 1913. Fracture of the right



Case No. 14. Mr. E. R. P. X-ray shows fracture of radius, with as perfect reduction as possible. Taken 3rd day after admission. Antero-posterior and lateral views.

lower third of radius. Impossible to get proper reduction or perfect approximation of fragments. Patient demanded perfect approximation. Open operation decided upon. Waited seven days. Fragments approximated by vanadium steel plate with three screws. Discharged in 16 days, perfect result.



CASE 15.—Mr. T. P.; age 20 years. Admitted to Flower Hospital Jan. 28th, 1913. Previous history of treatment for the last six months, for gastric ulcer with no relief of symptoms. Upon admission, extreme tenderness over the right hypochondriac and epigastric regions. Intense pain, epigastrium: agonizing shortness of breath: must sit up in bed. Lower abdomen absolutely free from pain and tenderness. Tendency to collapse. Diagnosis: Cholecystitis or perforation of a duodenal ulcer. Laparotomy. Stomach normal. Acute suppurative appendicitis with adhesions; stenosis of the gall bladder; gall bladder drained; abdomen closed. Improvement of all symptoms at once except slight dyspnoea at times. Discharged, cured in 23 days.

CASE 16.—Mrs. D. A.; age 44 years. Admitted to Flower Hospital Jan. 30, 1913, at 5.30 P. M. History of a fall three days previous, striking the lower spine with a resulting paralysis of bladder and bowels. No return from four enematae: excruciating pain: marked distension: rapid collapse: taken to operating room at 10 P. M. Laparotomy. Separation of the abdominal muscles due to distention. Large intestine remarkably distended: ascending colon and caecum bound down by strong bands of adhesion, Jackson's membrane. Small intestine, stomach and gall bladder empty. Gastropnoia. Impossible to replace large intestine, so ascending colon opened, gas expelled with 32 ounces of fecal fluid and enema. Lembert's suture. Appendix normal, but removed. No obstruction found. Hot saline irrigation of abdominal cavity. Abdomen filled with one per cent. oleum telesphoros and camphor solution. Abdomen closed. Temporary relief that night and the next morning. In the afternoon began to distend, and at night as bad as night before. No relief from enematae or medication. Secondary operation: Former sutures torn out: large intestine empty: small intestines, gall bladder and stomach widely distended: no leakage from former operation: small intestine opened, gas expelled with 20 ounces of fecal fluid, enematae and bile. Slight adhesions about stomach and gall bladder: entire alimentary tract from stomach to rectum taken out and massaged carefully inch by inch and about 20 more ounces of fecal matter expressed through anus on to operating table. No obstruction of any kind found. Patient in dangerous condition: abdomen filled with one per cent. oleum telesphoros and camphor solution. Abdomen closed hurriedly by through

and through silk-worm-gut sutures; cigarette drain, strychnine 1-30 and 1-60 in alternation every four hours. Next morning, improvement of all symptoms and no return of abdominal distension. Gastric distension relieved by stomach tube. Suppuration of wound about drainage tube but no fecal fistula: free from old trouble. Discharged, cured in 31 days. Diagnosis of this case, not positive, but probably an intestinal stasis, due to a temporary paralysis, either of sympathetic plexus or spinal nerves controlling intestinal tract.

In the treatment of these cases in comparison with other treatments, I have been able to make the following observations, which I think will be of interest, if not of use, to all of us. Namely:

#### A.—IN BONE WORK.

No. 1.—The skin must be in a healthy condition, better to wait at least seven days before operation, and not longer than 12, as then the bone and other tissues are less liable to become infected.

No. 2.—Vanadium steel plates and screws are preferable to the original Lane's plate and screws.

No. 3.—The wound edges should be protected by moist gauze after bone exposed.

No. 4.—Never plate a compound fracture. Never plate the bones of children.

No. 5.—The operator's and assistant's hands must be kept absolutely out of the wound, and all instruments entering the wound, must not be fingered.

No. 6.—Sutures must not be fingered and should be tied with instruments. Ligate only when absolutely necessary.

No. 7.—Apply a light, but snug, well padded plaster paris cast.

#### B.—IN ABDOMINAL GUNSHOT CASES.

No. 1.—Operate at once, the sooner the better, irrespective of patient or symptoms if you desire to help save life.

No. 2.—Linen or black silk sutures preferable to fine catgut for intestinal work.

No. 3.—Two rows of Lembert's sutures are sufficient, if properly done. First sutures include all coats of intestine and second, serous coat only.

No. 4.—Close approximation far better than too tight, with the danger of tearing and resulting infection.

No. 5.—Serous exudate given out that closes all avenues of escape within a few hours' time, so that feeding or enematae are possible with safety within six hours.

No. 6.—Perforations of large intestine are more liable to give a complicating peritonitis, so begin precautions at once.

No. 7.—If abdominal cavity wiped clean of foreign contents, it is not necessary to drain.

No. 8.—One per cent. oleum telesphoros with camphor poured into the abdominal cavity, has been useful in preventing infection and formation of adhesions.

No. 9.—Murphy's protoclysis, twenty to thirty drops per minute with a hypodermic of camphor and aboleine M. 20 as a stimulant, should be used in all cases.

In this list I have reported eight gunshot cases with three deaths, and, I think, I may be pardoned if I say of these deaths, that in case No. 2 it was absolutely impossible to save life, but, that, somehow I feel that in case No. 7, death was due to old age and the unavoidable delay in operating, with the subsequent loss of blood. While, case No. 10, I feel positive I could have saved, if the bleeding point had been found and the hemorrhage stopped.

Before closing, I wish to thank Dr. Bukk G. Carleton for his help and advice in the after treatment of case No. 4. Dr. John B. Murphy of Chicago, for his encouraging letter in the treatment of case No. 11, and Dr. William Todd Helmuth, my best friend, who, through his great generosity, has always aided me and made it possible for me to take charge of the majority of these cases.



**THE COMPLICATIONS OF ACUTE MIDDLE EAR SUPPURATIONS.**

BY

GEORGE W. MACKENZIE, M. D., PHILADELPHIA.

At last month's meeting of the West Jersey Homœopathic Medical Society, it was my privilege to present a paper on the subject of "Acute Middle Ear Suppuration." It is fitting, therefore, that I should supplement it this month with a paper on the subject of "The Complications of Acute Middle Ear Suppuration," for which opportunity I thank the Mercer County Homœopathic Medical Society.

In the former paper I referred to the causes of acute middle ear suppuration as (a) predisposing-pathologic adenoids and tonsils, (b) actuating-acute specific infections among which were included, acute lacunar tonsillitis, measles, scarlet fever, diphtheria, influenza, etc.

Although acute middle ear suppuration may occur in an individual not affected with enlarged adenoids, it should be considered rather the exception than the rule. I would like to add that, even, this exception is more apparent than real; for, if we were to examine all such cases carefully, we could find the adenoids acutely swollen. I have repeatedly observed children with insignificant adenoids, develop large ones in the course of an acute infectious disease; which in some instances have remained more or less enlarged thereafter. You gentlemen, no doubt, have observed these same changes in the tonsils under similar conditions.

Summing it up briefly: in those cases of acute middle ear suppuration occurring in individuals without previously enlarged adenoids, the acute specific infection produces an acutely swollen and infected adenoid, which in turn acts as the intermediary to spread the infection to the Eustachian tube and middle ear.

My object in referring to the causes of middle ear suppuration is to point out the fact that, at least, one of the causes—adenoids—may act, too, as a factor in prolonging the suppuration after it has once begun.

The tendency of acute middle ear suppuration is toward recovery after a few weeks. When it does not, the case may be considered complicated. Our duty then is to make a careful

search for the complication after a systematic manner. Let us begin our search by ascertaining if the causes of the original suppuration are still operative.

Since the acute specific fevers are self limited, they must be excluded. Let us look next to the predisposing causes—*adenoids and tonsils*, especially the former! If found, their early removal is indicated. By removing the tonsils and adenoids, you will be surprised to see how many protracted cases will clear up. The adenoids need not be large and obstructive to breathing; on the contrary, they may be relatively small, located obscurely from the casual observer, in the fossa of Rosenmüller.

A cause for delayed recovery which is not considered often enough is *lowered vitality* of the patient. There is unfortunately a class of individuals who, for one reason or another, are frail and susceptible to various ailments, who when they become sick, respond poorly to ordinary treatment. These are they born of weak or diseased parents; in some cases syphilitic; in others tuberculous; in still others for reasons, yet unknown to our science. Puny children too, who have suffered from previously debilitating gastro-intestinal disorders or other devitalizing diseases. Besides we have lowered vitality from underfeeding, improper clothing and housing and from sheer neglect. These patients need general treatment as well as special, at the hands of a good all-round general physician.

In the European clinics, notably those of Vienna, *pyorrhoea of the Eustachian tube* has been considered a cause of chronicity and, as such, must logically be considered a complication of acute middle ear suppuration. Beyond mentioning this complication, I do not wish to dwell long upon it, for my experience has been to meet it rather infrequently and then generally late.

Pyorrhoea of the tube calls for antiseptic washings and local applications of selected remedies. Success by this treatment, in my hands, has been somewhat doubtful. A preferable treatment is that of curettage after the method of Yankauer, with the object of destroying the diseased mucous membrane and effecting a permanent obliteration of the tube. With this operation I have been more successful.

A more frequent complication of acute middle ear suppuration is that of *obstruction of the Eustachian tube*. Occlusion, partial or complete, of the orifice of the Eustachian tube by ade-

noids has already been referred to. The tube may be obstructed from inflammatory swelling of its mucous membrane, which is always more or less present at the beginning of acute middle ear suppuration. This swelling diminishes after a certain period, permitting the tube to again become patulous. If for any reason, the swelling of the mucous membrane is prolonged, the suppuration of the middle ear is prolonged proportionately; since the normal drainage of the tympanic cavity, in the subsiding stage of the disease, is through the tube. If the suppurative process has been violent enough to destroy the mucous membrane in parts, adhesions may result causing partial or complete atresia. Furthermore, in a less violent but prolonged inflammation, metaplasia of the epithelium may occur so that the ciliated cells have been replaced by nonciliated cells, when drainage becomes impaired. In still other cases exudate from previously less violent inflammations may have become organized and cause partial obstruction. From whatever cause, obstructions of the Eustachian tube whether pre-existing or concomitant, with acute middle ear suppuration, are complications which should be dealt with accordingly in order to effect a cure of the acute suppuration. When purely mechanical, they should be dealt with mechanically; when purely inflammatory, with properly selected internal medicines.

We come next to the causes located in the middle ear, which operate to prevent perfect drainage. Among these may be mentioned, *adhesions or bands of fibrous tissue in the tympanic cavity*, the result usually, of some pre-existing attack of acute or chronic middle ear catarrh. They may be so situated as to partially or completely close off certain spaces; more often the epitympanum or attic, the antrum, less often the hypotympanum and pretympanum. The presence of these adhesions or bands may so interfere with drainage as to call for more than one free paracentesis or, even, a mastoid operation. As mechanical conditions they call, primarily, for mechanical interference, though medicines are not to be entirely tabooed.

The same causes that produce adhesions or bands of connective tissue may likewise produce a *thickening of the tympanic membrane*. A deposition of sero-fibrinous exudate on the inner surface of the membrane, the result of an acute secretory catarrh, which subsequently organizes may so thicken it as to make it very unyielding in the event of an acute middle ear suppuration. The pus not finding an exit through the Eustachian



tube, because of inflammatory swelling of its mucous membrane, nor through a perforation of the thickened tympanic membrane is retained under pressure and seeks a vent in the mastoid cells or windows to the inner ear. Thus we see how one complication can lead to still further complications to be mentioned later.

Pathologic thickening of the tympanic membrane may be recognized in the course of acute middle ear suppuration by its gray opacity and its dull surface. The surface lacks the polish of the normal membrane, evidenced by the absence of the normal brilliant reflex, looking not unlike the surface of spongy or porous ice.

The treatment should be a free paracentesis. Unfortunately these cases come to the specialist rather too late to be benefited by such simple procedures. The damage has already been done and secondary complications have taken place. These cases are not at all rare; the writer having witnessed quite a number this last winter.

Rarely it happens that the inflammation of the tympanic cavity is so intense as to produce *inflammatory oedema of the mucous membrane* sufficient to prolapse it into the perforation, effectually corking it. This condition cannot exist long before it seriously interferes with drainage, which means further complications just as much so as the condition last referred to.

Let us next consider the causes located in the external canal that may complicate an acute middle ear suppuration. Generally speaking, *obstructive conditions in the external canal*, including otitis externa eczematosa, furuncles, exostoses, impacted cerumen, atrasias (congenital or acquired), foreign bodies, etc., may be the direct cause of still more vital complications. Each of these, again, calls for its own special treatment. I wish here to call the attention of the general practitioner to the importance of looking into all discharging ears, after first cleansing them thoroughly with normal saline solution at the body temperature—using good illumination and a clean speculum. Further than calling your attention to the possibility of their presence, I will not take up your time now for a discussion of their treatment.

Any of the complications thus far enumerated, whether located in the Eustachian tube, external auditory canal or in the middle ear cavity may lead to complications in the mastoid antrum or cells, producing *mastoid empyema*. This condition is

perhaps the most frequently referred to of all the complications of acute middle ear suppuration.

When speaking of mastoiditis, most of us have in our minds a very vivid picture of it, with a typical swelling behind the ear; the auricle standing out from the side of the head, inclined forward and downward; narrowing of the external auditory canal from swelling of the posterior upper wall of the osseous canal; pain, tenderness and perhaps fever. Although this may be a text-book picture of acute mastoiditis, it by no means answers the description of every case. May I be pardoned, therefore, for modifying the picture, especially of the earlier stage of acute mastoiditis.

As a rule, but not always, acute mastoiditis appears in the course of an acute middle ear suppuration after a period of temporary improvement. Accordingly there is a flare up in the symptoms including fever, pain, tenderness and perhaps headache. The discharge may suddenly cease, or on the contrary may increase; at all events there is a change from the former condition of discharge. There occurs at least some swelling behind the ear, at first barely perceptible, but increasing with the progress of the complication. This swelling is due to thickening of the periosteum and can be determined by the finger tips of the examiner applied to the mastoid. It will be noted too that the periosteum is less movable, to the palpating fingers, over the affected than over the unaffected side. Otoscopic examination reveals a swelling of the periosteum of the osseous canal, especially the posterior upper wall, narrowing its lumen. These then comprise the more important early findings of acute mastoiditis which should prompt us to operate long before the text-book picture makes its appearance; for the book picture is one of mastoiditis plus a sub-periosteal abscess.

Unoperated mastoid abscess tends to break in one of several directions dependent upon the relative thinness of its walls. Should the external wall be thinnest, as is more frequently the case, the abscess will break externally: when we get a picture corresponding to that of the text books. Should the tip be thinnest, it will break downward, when there develops one of the types of so-called Bezold's abscess. Should it break upward through the roof—Tegmen antri—we get an extra-dural abscess of the middle brain fossa or a brain abscess or possibly a circumscribed pachy, or lepto-meningitis. Should the abscess break in a median-posterior direction, the results are an extra-

dural abscess or a perisinous abscess with eventual sinus thrombosis or cerebellar abscess or meningitis, circumscribed or diffuse; occasionally two or more of these conditions combined.

All of the conditions enumerated above are to be kept in mind as the possible sequella of acute mastoiditis and should prompt us to keep ourselves posted in the recognition of *early* mastoiditis; for the earlier the operation of mastoiditis, the less the risk to the patient's life from the more to be dreaded intra-cranial complications.

Any obstructive condition located in the Eustachian tube, external canal, or tympanic cavity itself, leads to retention of pus under pressure. This pressure may so devitalize the muco-periosteum lining of the inner wall of the tympanic cavity that caries or necrosis results. This in turn opens up a path of infection to the facial nerve or inner ear, or possibly both.

*Facial palsy* may occur as a complication of acute middle ear suppuration as a result of the causes just mentioned or otherwise. The facial nerve is particularly vulnerable in certain individuals. Careful study has shown that this vulnerability is generally due to a congenital dehiscence in the bony canal surrounding the nerve; so that the slightest affection of the middle ear is promptly followed by paralysis. At all events facial palsy in the course of acute middle ear suppuration, calls for prompt surgical intervention with the aim of accomplishing, perfect, drainage.

A rather unfrequent but very important complication of acute middle ear suppuration is that of suppuration of the inner ear: *labyrinth suppuration*. It is always fatal to hearing and often to the patient's life. The invasion of the inner ear with pus may occur through destruction of the median wall, after the manner referred to, or through one of the preferred ways—the round or oval window. A third possible way is by thrombotic changes in the blood vessels in the bone itself, as described by MacEwen. The symptoms are briefly: complete deafness of sudden onset; severe vertigo, lasting for several days, compelling the subject to seek the recumbent position; persistent nausea and vomiting for several days; equilibrium disturbance, which causes the patient to fall laterally to the well side when he attempts to stand; spontaneous nystagmus to the well side. For further details and the tests used in its diagnosis, you are referred to the more recent text books and former papers on the subject of "Labyrinth Suppuration," by the au-



thor, since the subject is too large for me to dwell upon at this time. I would like, however, to add that labyrinth suppuration is usually preceded by a milder condition of the labyrinth, either congestion or a mild serous inflammation, in which vertigo is the most prominent symptom. We may accept, therefore, the symptom of vertigo, especially when marked, as an indication of surgical importance.

In this incomplete paper, my effort has been to point out the more frequent complications of acute middle ear suppuration, some of apparently minor importance, and how they in turn bring about the major complication, and to draw your attention to the importance of early recognizing them.

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#### A CONTINUATION OF RHUS POISONING.

BY

JOSEPH C. GUERNSEY, A. M., M. D., PHILADELPHIA.

FURTHER acquaintance with Rhus poisoning has induced me to add the following to what I wrote on the subject in the *HAHNEMANNIAN MONTHLY* for March, 1913. In this "continuation" I desire to introduce much new material; to modify some of my former statements and to elaborate other statements.

It is so well known that people are frequently poisoned while near the Rhus plant but without direct contact—sometimes merely by the wind blowing from the plant towards them, that it was the generally accepted belief the toxin was volatile. The real cause of such poisoning is doubtless that the pollen, or the plant hairs (fine hairs found on the leaves, especially along the margins) or some dust from the plant, is carried by breezes and air currents; frequently also clothing, tools or animals after being in contact with the plant—if only by brushing against it—are able to convey the poison to susceptible subjects. Such explanations are most probable when realizing how minute a quantity suffices to induce inflammation.

Franz Pfaff,<sup>1</sup> M. D., of the Harvard Medical School, in

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<sup>1</sup>"On the Active Principle of Rhus Toxicodendron and Rhus Venenata," by Franz Pfaff, M. D., Ph. D. From the Pharmacological Laboratory of the Harvard Medical School.

1897, showed that the toxin of Rhus is a non-volatile, oily substance, which he extracted and named "Toxicodendrol." Of this substance as little as 1-1000 mg. suffices to produce the typical dermatitis.

It is not known why certain people are much more susceptible than others, although various attempts have been made to solve the mystery. One thing which repeated experiment has proved is that there are but few, if any, persons wholly immune. Some individuals are so slightly responsive that they are but very slightly affected although actively handling the plant—at times may even seem to be wholly free from the injurious action of the poison; yet *careful experimentation "indicates universal susceptibility,"* i. e., every living mortal suffers to a greater or less degree from contact with Rhus toxin. Ford,<sup>2</sup> while stating that many persons are quite resistant to the action of Rhus toxin, expresses the opinion that the so-called natural immunity is really an immunity acquired in individuals in whom as children the effects from handling the plant have gradually worn off. He concludes by saying that *complete natural immunity*, when put to experimental test is exceedingly rare.. Warren,<sup>3</sup> likewise thinks "the belief in absolute immunity is a delusion."

The above being the case, that no individual enjoys absolute freedom from the venomous toxin, it especially becomes one of the prime objects of the medical profession to rescue mankind from the scourge of Rhus poisoning by discovering a safeguard which should speedily be ascertained and widely disseminated throughout the land.

It is an interesting fact that the serum contained in the blisters of Rhus dermatitis is non toxic. Pearson showed this experimentally in 1880. Further, Adelung<sup>4</sup> asserts: "I have repeatedly tried in vain to produce dermatitis by rubbing in the serum from vesicles." As stated in my former article, the poison of Rhus does not enter the blood but is purely a local affection.

According to Syme,<sup>5</sup> the toxin is a glucoside. "The poison

<sup>2</sup>W. W. Ford: "Antibodies to Glucosides with Special Reference to Rhus Toxicodendron," Jour. Infectious Diseases, 1907, IV, No. 4.

<sup>3</sup>L. E. Warren: "The Poisonous Principle of Rhus," Pharmaceutical Journal, October 30, November 6, 1909.

<sup>4</sup>"An Experimental Study of Poison Oak," by Edward Von Adelung, M. D., Oakland, Cal. From the Hearst Laboratory of Pathology and Bacteriology, University of California.

<sup>5</sup>W. A. Syme, Johns Hopkins Univ. Bulletin, 1906: "Some Constituents of the Poison Ivy Plant."—Pamphlet.

is a complex substance of a glucosidal nature yielding, on analysis, gallic acid, fisetin and rhamnose."

<sup>4</sup> "Considerable popular testimony is available upholding the possibility of vaccination against Rhus by ingestion of the plant or its derivatives. There are those who state that the tincture of the fluid extract taken internally prevents attacks on subsequent contact with the plant. Likewise, many persons claim to have gained immunity by chewing or eating small quantities of the Rhus leaves. This prophylactic measure is said to have been found valuable by the engineers of the Union Pacific Railroad Company while the line was being built through poison oak country. Similar testimony is obtained from residents in the Adirondack Mountains. And I am told by an eye witness that Indians and other residents of New Mexico habitually eat the leaves each spring to avoid poisoning during the summer. Experimental confirmation or scientific observation of the folk-sayings is, however, entirely lacking. But they open the large question of acquired immunity."

Many homœopathic physicians declare they protect their patients—those going into the woods on hunting and fishing trips or going away for the summer into the country, by administering potentized Rhus.

*The large question of acquired immunity* is one that should mightily stir the medical profession—nor is the solution at all impossible. At medical colleges "experimental" classes are not infrequently formed and much good has resulted from their efforts. Here is an opportunity to immeasurably benefit a large portion of the human race. Let a "Preventive Union" be organized at one or more medical institutions whose object shall be to learn:

- a. What will afford immunity against Rhus poisoning?
- b. How can it be best prepared and most successfully administered?

The plant being equally poisonous fresh or dry, a sufficient quantity can be procured during the summer to last through the winter for experimental purposes. As an initial step, before handling the plant, those engaged could partake plentifully of Rhus from the tincture up to the higher potencies and observe whether any exemption from its infection is gained. Those making the trial should read attentively <sup>4</sup> "An Experimental Study of Poison Oak," published in *The Archives of Internal Medicine*, February, 1913.



The investigation need not be attended with any great amount of suffering. Potent remedies, endorsed by the most eminent authorities, for Rhus dermatitis are so plainly set forth in this article that any victim to this *experimentum crucis* for the love of humanity, need entail only a modicum of discomfort, lasting but a few days—possibly only a few hours. The winner of a crusade against Rhus who establishes immunity from its poison, will place his name in the annals of medicine among the highest upon the roll of those devoted physicians who have toiled and suffered for the benefit of their fellow beings.

4 “A large majority of people living in the country find their enjoyment seriously curtailed by the menace of the poisonous Rhus plants. And besides this restriction of healthful pleasures, there is an unestimated monetary loss to laborers and construction companies operating in infected regions, which is not inconsiderable. Yet, in spite of these well known facts, very little has been attempted and still less accomplished, to abate this widespread evil. The plants specially referred to are poison oak (*Rhus diversiloba*), poison ivy (*R. toxicodendron*) and poison sumach (*R. venenata*), which form a widely distributed group.”

Birds eat the berries and thus, with the air currents, become the means of distributing the plant extensively over the country besides constantly replacing its seed in localities where the growth has been eradicated.

The familiar adage of our remote ancestors, “An ounce of prevention is worth a pound of cure,” has developed into a demand for such complete prevention that perhaps there will be nothing left to cure! The age of Preventive Medicine is upon us and there are eager strivings on all sides to discover and utilize proper prophylaxis against every known disease. The battle has been waged and won against small-pox, diphtheria, typhoid fever, malaria, yellow fever, rabies,—why not ascertain and promulgate a safe and sure defense against Rhus poison? Any medical college, scientific body or solitary individual, may well be proud to grasp this honor.

At a large military dinner in celebration of the fifty-second anniversary of the Battle of Gettysburg, a prominent General said: “The thought of the present era is to *prevent war!*” In

his recent annual report, the Fire Marshal of one of our largest cities says: "We have an efficient fire extinguishing department which does good work—but *prevention of fire is better!*"

*Prevention*:—The best preventive measures to adopt when passing through dangerous territory or when handling Rhus plants for commercial, scientific or any other purpose, besides wearing gloves, is to anoint the skin, hands, arms and face with cotton seed oil which should be thoroughly washed off a few hours after exposure, with hot water and soap. This furnishes fairly certain protection.

As a precautionary measure after a country ramble through woods, across fields, along the banks of streams, etc., it is a safe rule to always disinfect one's self, within a few hours, by taking a hot bath of the whole body, *including the hair*, and using quantities of hot water and strong soap—soft soap is most efficacious for this purpose. Make a thick lather and use the scrubbing brush vigorously; also apply alcohol to the parts freely. It is advisable to wash the exposed parts *repeatedly* with fresh quantities of alcohol and soap and water. The finger nails should be cut short and also perfectly cleaned with the scrubbing brush and alcohol. Many and many a case of Rhus poisoning and intense suffering, will thus be prevented.

After the bath, none of the clothing worn during exposure to the poison should be resumed. Experiment shows that the poison of the Rhus plant remains potent to do its evil work even after being subjected for one hour to a temperature of 212 F.; therefore clothing that has become infected should be rejected.

Oily preparations or anything which dissolves the poisonous oil if used and not immediately removed, will spread the poison and give it a larger area on which to work.

In my previous paper upon Rhus poisoning (HAHNEMANNIAN MONTHLY, March, 1913), on what appeared to be sufficiently good authority, I recommended, among other local applications, Ammonia (Hartshorn), Hydrogen peroxid, Sodium hypo-sulphite, Aristol. Hospital experiments made by <sup>4</sup>Adelung indicated that Ammonia does not destroy the poison; Hydrogen peroxid used on a patch of dermatitis was found inert; Aristol appeared to be of no value; Hypo-sulphite of sodium failed to show curative effects on patches of dermatitis.

Green soap (soft soap) deters the poison of Rhus.

Dermatitis painted with five per cent. ichthyol collodion daily, produces most beneficial results.

Full officinal strength tincture of iodine undiluted with water or alcohol, destroys the poison. It also has curative property and can be applied directly to the dermatitis; it will burn and discolor but quickly subdues the itching and promotes prompt healing. A milder and useful application is to use 90 drops of water mixed with 10 drops of tincture of iodine.

A hot solution of Potassium permanganate, locally, is curative; unfortunately it leaves a mahogany brown stain which is sometimes difficult to remove.

When the vesicles become infected and pustular the permanganate is useless; under such circumstances the parts should be bandaged in a hot solution of mercuric chlorid.

Magnesium sulphate (Epsom salts) is curative. Use a saturated solution applied on gauze and held by bandage.

Water, as hot as can be borne, readily relieves the itching and assists the cure.

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CORPUS LUTEUM EXTRACT IN GYNECOLOGY.—By Dr. C. F. Burnam (*Journal American Medical Association*, August 31, 1912). —The author presents the results of his observations with this substance in contrast to the ordinary ovarian extract in cases of ovarian insufficiency in woman. Tablets of this substance, when freshly made, seemed to be as effectual as the raw material and were employed in doses containing 20 grains of the fresh corpus luteum of the sow. Little or no toxic effects were observed even in large doses and the substance seemed to control the nervous symptoms in patients at the menopause whether natural or artificial. The extract seemed also to be of value in cases of insufficient internal ovarian secretion during the menstrual life, and was found efficient in inducing menstruation in young women suffering from functional amenorrhea. It was also found that when these patients were fat a reduction in weight usually occurred. The author believes that the corpora lutea of other animals should also be employed in order to determine their value in comparison with that of the sow. From clinical experiences the author is inclined to believe that corpus luteum possess different properties due to different chemicals. One of these substances causes hyperemia of the pelvic organs, another relieves nervous symptoms of a toxic character, as at the menopause. It would seem as if this product acted as a neutralizer, since even larger doses of the same cause no disturbances of a toxic nature. On the other hand, the toxic results of intravenous injections of the luteal extracts, as well as the nervous phenomena of menstruation show that there must be some toxic material present which is not absorbed from the stomach or the intestines. He believes that in the future these various substances may be separated.



## Transactions of the Homoeopathic Medical Society of the State of Pennsylvania.

### BUREAU OF SURGERY

HERBERT P. LEOPOLD, Chairman.

#### SURGICAL DISEASES OF THE SPLEEN.

BY

H. L. NORTHROP, M. D., PHILADELPHIA.

It happens that there is less to be said of the spleen, from a surgical point of view, than of the stomach, liver, or even the pancreas. The average text-book on surgery is far from being burdened with chapters on splenic diseases; the average surgeon sees probably fifty cases of gastric ulcer or cancer to one of splenomegaly or Banti's disease. It is not my intention to write an exhaustive paper on all splenic lesions which are of a so-called surgical character, but first to state some important and, I hope, interesting facts relating to my subject in hand, and then to report the diseases with which I have had personal experience.

The spleen lies under the ninth, tenth and eleventh ribs; its long axis is directed from above downward and forward, and is almost identical with that of the tenth rib. Its ligaments are very extensive and contain numerous large blood vessels. The length of the spleen is  $4\frac{1}{2}$  to 5 inches, and its average weight is seven ounces. Its anterior border is fairly sharp and in 95 per cent. of all spleens is notched at one or more points.

The male sex predominates in cases of injury of the spleen.—300 men to only 60 women. A large percentage (5.18) of injuries of the spleen are subcutaneous, and diseases which enlarge the spleen, such as malaria, miliary tuberculosis, and typhoid fever, are potent, predisposing, etiological factors in cases of subcutaneous rupture. As a rule no external evidence of rupture can be found and the symptoms of internal hemorrhage place all other symptoms in the background. In cases of rupture the mortality is about 75 per cent. from hemorrhage and 10 per cent. from peritonitis. Another authority places

the mortality as high as 96.2 per cent. in rupture, one half of the patients dying within an hour after the injury, and most of the remainder within twenty-four hours.

"The mystery of the spleen is a most fascinating surgical and physiologic inquiry. Surgically it is unique, because, when subjected to operation, its complete removal is necessary. Writers enumerate eight causes for its removal; injury, abscess, cysts, new-growths, malarial enlargements, splenic anemia and wandering spleen." (Mumford.)

#### SUBCUTANEOUS RUPTURE.

CASE 1.—Mr. C. C., age 24. While crossing the street, reading a newspaper, was struck in left side by the shaft of a coupe. Examination shows patient severely shocked, surface cold, of death-like pallor, radial pulse rapid and compressible, frequent vomiting. No external evidence whatsoever of any injury. Has severe pain in left side of abdomen, high up. Considerable abdominal distention, marked rigidity of the recti muscles, flat percussion note throughout left flank, increasing in area. Diagnosis: Internal hemorrhage, probably due to rupture of the spleen. Immediate operation proved this surmise to be correct. When the peritoneum was incised the free blood spurted six feet into the air. The peritoneal cavity contained a large quantity of liquid and clotted blood. The spleen was found enlarged, and the upper border presented a laceration two inches long and one half an inch deep. I believed splenectomy inadvisable because of the patient's shocked condition and because the rupture was only a partial one, so I packed the laceration and the surrounding peritoneal cavity with gauze. During the operation the patient was infused with three pints of saline solution. Recovery.

#### HEMATOMA, PERISPLENITIS, ABSCESS.

CASE 2.—W. H., male, age 18 years. Is left-handed. When throwing a stone four weeks ago felt a sharp pain in his left side under the ribs, which was aggravated by taking a deep breath. Now he has a feeling of fulness and weight under his short ribs on the left side. Examination shows bulging of the left upper abdomen, increased splenic dullness and the presence of a large tumor, whose right-hand margin is notched. Exam-

ination of his blood shows hemoglobin 58 per cent., red count 4,130,000, white count 5,800. Diagnosis, enlargement of the spleen. Advised exploratory incision.

Operation exposed a spleen extending nearly to the median line and as low as the umbilicus, and attached to the parietal peritoneum and great omentum by a number of adhesions. The spleen was softened over the entire area which presented in the wound. I then believed that the throwing of the stone with the left hand five weeks before had caused an intrasplenic hemorrhage, or hematoma, and a perisplenitis. I closed the wound and awaited developments. After four weeks, symptoms of local inflammation with a chill and rise of temperature developed. An incision through the original scar liberated a large quantity of pus and fragments of clots, which came from within and around the spleen, evidently the products of a degenerating hematoma. The spleen was tightly glued to the surrounding structures. Although a very sick man, he made a complete recovery.

#### SPLENIC ANEMIA, OR SO-CALLED SPLENOMEGALY.

W. B., male, age 21 years, enjoyed perfect health until two years ago. During this time he had pain in his left loin and his general health failed. He became anemic and his legs and ankles swelled. Examination showed his left loin bulging prominently with a circumscribed growth extending two fingers' breadth to the right of and below the umbilicus, with a sharply defined border which possibly was notched. The surface area of hepatic dullness was somewhat increased, and the peritoneal cavity contained a sufficient amount of ascitic fluid to give rise to a percussion wave. A blood examination showed hemoglobin, 40 per cent., red cells 1,900,000, color index 1, white cells 1,400. Differential count was normal and no nucleated cells were observed. Diagnosis, splenic anemia, but no hepatic cirrhosis. Hence, not Banti's disease, strictly speaking.

My operation, in this case, consisted of a splenectomy. Dr. S. W. Sappington reported the specimen to be fairly normal in shape and color. The capsule was whitened and thickened in various areas. The organ weighed 3.080 grams, and measured 30-18-11 centimeters, (weight 99 ounces, measurements 12-7-4½ inches).

Microscopically, the changes were confined to the endothelial



cells and the blood mass. The greater number of fields showed a marked increased proliferation of endothelial cells. It is easy to understand the great enlargement of the spleen in the light of the tremendous proliferation of the endothelium and to a less extent of the increased blood count.

The splenectomized patient made an uninterrupted recovery from his operation; a blood examination, made twenty-five days after splenectomy, gave hemaglobin 65 per cent., red cells 2,440,000, color index 1.3, leucocytes 4,500. Differential count normal and very few red-cell changes. No nucleated red cells.

This man continued to improve after leaving the hospital until he contracted a cold with severe pleuritic pains at the base of the left lung. After that his appetite waned, the anemic pallor returned, the hepatic enlargement increased and the feet and legs swelled. He died.

#### BANTI'S DISEASE.

C. D., 19 years, living in the same town and of the same nationality (German) as W. B., the case just reported. In September, 1911, and in March, 1912, he nearly died from severe hematemesis (second time six quarts). Following last hemorrhage gradual development of ascites. He is of an anemic appearance and presents an abdomen full of ascitic fluid and a large, smooth, splenic tumor, as indicated by the accompanying photograph. Urinalysis negative. Blood examination gave hemoglobin 38 per cent., red cells 3,580,000, white cells 4,100, color index 1, polynuclears 81, mononuclears 19. Red cells vary in size and shape slightly. No basiphiles or nucleated red cells. No parasites. Blood is that of secondary anemia.

I performed a Talma-Morris operation with two incisions for drainage. The main incision was three inches in length through the left semilunar line over the splenic tumor. Upon opening the peritoneum a large quantity of straw-colored fluid escaped. The spleen was found to be enlarged, as illustrated, and covered with small whitish areas.

The liver was much decreased in size and cirrhotic. I rubbed the upper and under surfaces of the liver and spleen and the parietal peritoneum with gauze. I next attached the omentum to the parietal peritoneum by no 1 and 2.20 day chromic gut, sewing through the entire thickness of the abdominal

wall. The wound was then closed in the usual manner and I made a small incision about one and one-half inches in length through the abdominal wall on each side below the umbilicus and inserted and sutured a Penrose drain in the wounds.

The disease in this case was too far advanced to permit of a splenectomy being done with a fair assurance of safety, so the epiploexy was chosen instead. In performing the latter I carried out the Mayo idea of making a pocket in the sheath of the rectus muscle posteriorly and tucking and suturing a piece of omentum into it. This brings the omental vessels into close proximity with the deep epigastric and internal mammary veins and thus materially aids the new collateral circulation.

This patient's hospital period was of the average duration, and he was discharged in good, general condition. According to the latest report from him he is doing nicely and is enjoying fairly good health.

If another case of ruptured spleen comes under my care I shall make an effort to close the splenic wound by suturing if the laceration is not too extensive. This no doubt can be readily done by using the blunt, pointless needle which is so useful in suturing the kidney and the liver, threaded with very soft, flexible catgut.

Moynihan says that primary abscess of the spleen is a possibility, but a fanciful one. It is said to have followed injury or a strain, but has then probably been due to infection subsequent to the development of a hematoma. This is undoubtedly what occurred in my case of hematoma and abscess. It is also the manner and formation of blood and serous cysts. There is, of course, at first, a collection of pure blood, the result of an injury to the gland and the hemorrhage, which is the precursor of the cyst, may be either parenchymatous or subcapsular, more frequently the latter. It is this which accounts for the frequency of the external adhesions.

It is impossible to make any accurate statement of the results, either immediate or remote, of splenectomy for splenic anemia. A misunderstanding and misuse of terms is partly responsible for this, although a lack of definite knowledge of the pathology and inaccurate methods of diagnosis are also to blame. For instance, simple splenic hypertrophy has been diagnosed Banti's disease in its early stage, and cirrhosis of the liver accompanied by hematemesis from dilated gastric veins

and by enlargement of the spleen has been mistaken for Banti's disease in its later stage.

Banti's disease, or splenic anemia, is characterized by splenic enlargement which cannot be correlated with any known cause; absence of enlargement of the lymphatic glands; leukopenia, or at most, no increase in the number of white blood cells; an extremely prolonged course, lasting for years; and a tendency to hemorrhages, especially from the gastro-intestinal tract. The reduction of the leucocyte count is a most characteristic feature. Moynihan says that in one case of splenic anemia he was asked to see a patient, a man of thirty-four, with a view to an operation for hemorrhage from a supposed duodenal ulcer.

Banti described three stages in the evolution of splenic anemia: in the first, anemia and splenic enlargement are found, the former being secondary to the latter; in the second stage cirrhosis of the liver commences; in the third stage there is ascites. The progress of the case is steadily downward; after the onset of the cirrhosis the health of the patient often fails rapidly.

Without splenectomy the disease is necessarily fatal, and if the operation is to prove of any value in arresting the disease, it must be performed before unalterable changes have occurred in the liver or other parts.

Splenic anemia is an early condition and Banti's disease is a secondary and later stage of one and the same pathologic process and ensemble.

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### GENERAL DIAGNOSTIC METHODS.

BY

H. M. EBERHARD, M. D., PHILADELPHIA.

WHEN we realize that diseases of the upper abdomen have many symptoms in common, it is not surprising that clinicians are striving for definite means of diagnosis. My idea to-day is not to cite many difficult laboratory tests, but to give a few diagnostic aids that can be used by all practitioners of medicine and surgery. The suggestions I make are not new, but I can positively say, are too often forgotten.

One of the first considerations, and I may say the most important, when examining a patient, is to obtain a careful and



painstaking history. It is often possible by the history alone to make an accurate diagnosis. When we consider how pathognomonic are the symptoms of gastric and duodenal ulcers, viz., pain relieved by vomiting, eating, or alkali, to return again when digestion is at its height, acid eructations, which almost set the teeth on edge, etc., we can see the value of a good history.

Take again the characteristic fecal symptoms of pancreatic diseases, viz., large, bulky, white or clay colored acid stools, which show evidences of undigested food, and we have another proof of the great importance of a carefully taken history.

Next, let me speak of the means at your command for deciding between a functional and an organic abdominal disease.

To this end, let us study the patient's *habitus*. For all practical purposes, we need only know the normal *habitus* and *habitus enteropticus*. What do we mean by these terms? The main characteristics of a *habitus enteropticus* are: A long, small and usually narrow, flat thorax with a decidedly contracted costal angle. The ensiform is the apex of an acute angle. If one would draw a line between the ensiform and umbilicus, and another at right angles to this, and extending to the anterior axillary line, he would find the vertical line much longer. In normal *habitus*, on the other hand, the vertical line from the ensiform to the umbilicus would be about the same length as the one horizontal to it, and also extending to the anterior axillary line.

Briefly, the significance is this: In *habitus enteropticus*, the upper abdominal organs occupy a more vertical and elongated position, and are thus subject to functional derangements. A patient with *habitus enteropticus* is more liable to have gastrop-tosis and enteroptosis, where in normal *habitus* the trouble would be more likely of organic origin. Do not understand me to say that no organic lesion can occur with *habitus enteropticus*; it often does, but is not usual.

Next, the often forgotten *spinal pressure points*: These are corroboratory and with a careful history, gastric and fecal analysis give weight to a likely diagnosis. Clinicians differ as to the frequency of occurrence of these pressure points. My experience has been that if carefully looked for, they can be frequently found when not supposed to exist.

In ulcer of the duodenum and stomach, if deep, firm pressure

is made to the left of the tenth, eleventh and twelfth dorsal vertebrae, a tenderness is often found.

Gall bladder and gall duct troubles will give a similar tenderness to the right of these vertebrae. In gastro-enteric, diseases secondary to a nervous base, tenderness will often be noted along the entire spine on either side with especial reference to the spine of the vertebrae of the cervical region.

Next, let us consider the benefit obtained from gastric analysis:

Recently, there has been much discussion as to what real good is obtained from a chemical examination of a stomach. Some authors, going to the extreme, have placed little credence upon gastric findings. That a chemical investigation of the stomach has value when properly interpreted is an overwhelmingly established fact, notwithstanding the arguments of extremists. No clear thinking clinician would analyze a stomach, and try to make a diagnosis from it alone. Taken, however, in conjunction with a well written history, cardinal subjective and objective symptoms, fecal and blood examination, we have in gastric analysis, a means for diagnosis absolutely indispensable.

I believe intra gastric investigation has done more for the prevention of gastric carcinoma by pointing the way to early surgical interference than any other means of diagnosis.

A knowledge of the gastric chemistry of a patient is of enormous value in planning a diet, not alone for one who is suffering from a primary stomach disease, but also a disease referring symptoms to the stomach. I know of many cases of pulmonary tuberculosis, ruptured cardiac compensation, interstitial and parenchymatous nephritis that were markedly benefited by planning a diet suitable to the chemical state of the stomach. I believe that no physician has a right to prescribe dilute hydrochloric acid, pepsin, etc., for any stomach complaint, without first ascertaining the stomach's chemistry. For instance— if a patient threatened with a gastric ulcer who already has a marked hyperacidity is given dilute hydrochloric acid, pepsin, etc., the clinician is simply helping the development of the impending ulcer. To get the best results and greatest information from a gastric analysis, it is necessary to start correctly. Have your patient take, twelve hours prior to the analysis, as heavy a supper as his stomach will permit. With this, give twelve small currants. These should not be chewed, but swallowed whole.

From then on, until the analysis begins, permit no food or water. About twelve hours after last taking food, pass an ordinary stomach tube into the fasting stomach. It is best to use a tube of very large calibre, about 36 or 38 F. When the tube is in the stomach, have your patient gently eructate, and see if there is any return from the fasting stomach. Note carefully the amount expelled, paying particular attention to see if the currants are returned. Any amount of gastric juice up to 20 c.c. is considered normal; any quantity beyond that, pathological. If the currants are found, you have positive evidence of a gross error of motility which suggests surgical intervention. Of all the functions of the stomach, motility is the most important. You may have a stomach so atrophic that free hydrochloric acid, pepsin, rennet and mucous cannot be found, but so long as its motility is good, a patient may go through life without a single symptom referable to the stomach. If no juice or currants are found, it is best to wash the fasting stomach with a liter of plain water, and remove with a Bassler test meal bottle. I have often found gastric juice and currants with this bottle when ordinary syphonage failed to show anything. At times, the simple passage of an ordinary tube into the fasting stomach will show food remnants or stagnation of food eaten several days before. Examination of this retained substance may show lactic acid, Boas-Oppler bacilli, blood, etc., and suggest some organic change.

I will not take up your time by going into the process of gastric analysis; this you can find in any standard text book.

Just a few words regarding the diagnosis of gastric carcinoma:

At present we have no positive means of diagnosis without an exploratory laparotomy. We have, however, a test that, in my hands, has been 70 per cent. efficient, viz., the *tryptophan test*. Briefly stated, this test hinges upon the fact that carcinomatous tissue in the stomach secretes an enzyme analogous to trypsin. In a normal stomach, the digestion of a protein usually goes only to the stage of a peptone, while a carcinomatous stomach will digest proteins to the point of an amino acid. The simplest representative of an amino acid is a dipeptid of which tryptophan is easily recognized.

If, then, in testing a stomach prepared for the tryptophan test, tryptophan is found, it is presumptive evidence other symptoms agreeing that a cancer of the stomach exists.



It is often important to differentiate between a gastric and duodenal ulcer. It is known that gastric ulcers frequently undergo malignant degeneration, and that duodenal ulcers are not so prone to this change. It is evident, then, that the clinician must, at times, insist upon operative interference for gastric ulcers much more strenuously than he would for duodenal ulcers. At times, it is almost impossible to differentiate between a gastric and duodenal ulcer, but a few simple tests may be helpful.

If you will wash a stomach in the morning and give 100 c.c. of a one per cent. solution of glacial acetic acid, in many instances, a pain similar to the pain suffered ordinarily will occur. Usually, ten to fifteen minutes after the introduction of the acetic acid solution, the pain will begin. If it does not in twenty minutes, you can withdraw the solution and assume that an ulcer does not exist in the stomach. One great advantage of this test is that the acetic acid solution, at times, dissolves hemin crystals from the ulcer, which will be evidenced by a positive reaction for occult blood. Some clinicians use dilute hydrochloric acid in the same way, but this solution has the disadvantage of not giving a reaction for occult blood.

A duodenal ulcer will often give a reaction for occult blood in the feces. If occult blood is found to be negative in the gastric filtrate, and positive in the feces, it is presumptive evidence of duodenal ulcer.

A very simple method for the detection of duodenal ulcer is the swallowing of a silken white cord to the end of which is attached an ordinary shoe button. On retiring the patient is made to swallow the shoe button and cord, the proximal end of which is tied around the ear, or pinned to the shoulder of the gown. In the morning, it is removed, and carefully examined for a rust colored stain. If found, at a point corresponding on the cord to the duodenum, it suggests duodenal ulcer.

The *gastro diaphane* is a valuable instrument for the detection of the position of the stomach. This instrument, as you know, is simply a soft rubber stomach tube into the distal end of which is fitted a small incandescent lamp. By swallowing this tube, the clinician can, by transillumination, see the position of the stomach. After some experience, he will be able to tell the difference between a normal transillumination and one abnormal. When the transillumination is found lessened or

spotted, it suggests some change of the anterior stomach wall.

Just a few words regarding the gastroscope. This instrument is still in its infancy. I have used it many times, but can say it has never repaid mine, nor the patient's efforts. In the X-rays, we have a more potent means of diagnosis. I have frequently seen the X-ray change a diagnosis made by all other recognized means. This recalls a case in which the patient was supposed to have an obstruction at the pylorus, that the Roentgen rays proved to be nothing other than an enormously dilated oesophagus.

I could cite many other instances in which the X-ray has changed the diagnosis, but time does not permit. Let me dwell, however, for a few minutes upon the study of the peristaltic waves of the stomach. This requires special apparatus, and a trained man to interpret what he is shown upon the screen.

Normally, the peristaltic waves are seen to be rhythmic and regular in occurrence. If some organic lesion of the stomach exists, we note an interference in the peristaltic wave at the site of the lesion. It is extremely valuable in the early diagnosis of gastric carcinoma, ulcers of the stomach, adhesions, hour glass contractions, etc. Physicians and surgeons would do well to have cases examined by the X-ray in which a doubtful diagnosis exists.

#### INTESTINAL DIAGNOSIS.

We are not so fortunate in diagnosing diseases of the intestines as we are in those of the stomach.

Our knowledge of the intestinal canal is gained mainly through a proper interpretation of fecal findings. If physicians would only stop a few minutes and pay a little attention to the macroscopic appearance of feces, many errors of diagnosis would be obviated.

I want to briefly outline a method of investigation, which any of you can use without much trouble. If your patient's condition permits, give a diet which represents a protein carbohydrate and fat. For this purpose, I usually prescribe the following:

7.30 A. M.— $\frac{1}{2}$  pint milk or tea or cocoa, and plenty of milk. With this, give a roll and plenty of butter, plus one soft boiled egg.

10.30 A. M.—A dish of oatmeal gruel cooked in milk (strained), salt or sugar permissible.

1.00 P. M.— $\frac{1}{4}$  lb. finely chopped lean meat, broiled, rare, interior raw. One cup potato broth (strained).

4.00 P. M.—Same as 7.30 A. M., but no egg.

7.00 P. M.— $\frac{1}{2}$  pint milk with a roll and butter, plus  $\frac{1}{2}$  of a soft boiled egg.

This is given for three or four days consecutively, and a fresh stool saved each day for examination.

Now, as to its examination: The benefit of the plan I want to suggest is that it requires no special laboratory apparatus; can be expedited in a few minutes, and often points the way toward the diagnosis. It must be remembered, however, that fecal examinations are still in the primitive stage, and the last word has not been said by any means.

First, note the color; if milk is taken with the test diet, it will be light yellow; if cocoa, a reddish brown.

Test reaction with litmus paper: Normally, it should be neutral or faintly alkaline. Odor: that of ordinary feces. Consistency: that of butter, at room temperature.

Next, thoroughly mix the specimen with a wooden spatula, and select from the mass, a piece about the size of a walnut. Transfer this to a porcelain mortar, and add distilled water, stirring all the time, until the consistency of sauce. Pour some of this on a glass, preferably with a dark base, and spread uniformly smooth.

Normal feces from the test diet should be brown with spots of brown or reddish brown in it. Some chaff, the remains of the oatmeal gruel and cocoa, otherwise it is a homogeneous mass of debris.

*Pathologically:* Of the many diseases, let me cite one which I think is the best representative, and gives the most classical picture. In diseases of the pancreas, we find, usually, a large bulky, foul smelling, very acid, white or clay colored stool. Close inspection would reveal the white color is mostly neutral fat. This fat is frequently in such abundance as to give the appearance of a distinctly oily or greasy look. Interspersed with this fat, will be found meat fibres which, if subjected to the microscope, will show cell nuclei. The existence of cell nuclei in the feces is positive evidence of pancreatic trouble.

Physiologists agree that the pancreas digest muscle fibers and their cell nuclei completely. If, however, the stomach lacks free hydrochloric acid, often the connective tissue of



meat is not dissolved. This in turn does not allow the pancreatic juice to properly erode the cell nuclei and muscle fiber, so they are often found in the feces when the pancreas is normal. Taken, however, in conjunction with symptoms suggesting pancreatic disease, viz.—persistent emaciation, palpable pancreas, large, foul-smelling acid stools, etc., the finding of meat fibres with their cell nuclei in quantity, excessive fat, etc., suggests strongly pancreatic disease.

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### DUODENAL ULCER.

BY

W. N. HAMMOND, M. D., PHILADELPHIA.

THERE was no differentiation between gastric and duodenal ulcer until about the year 1900, and the literature and teaching of gastric ulcer included the ulcer found in the duodenum.

At that time there began a definite appreciation of duodenal ulcer as a distinct lesion, and since then it has been found to be more than twice as frequent as ulcer of the stomach with a greater morbidity and mortality; acute and chronic perforation taking place much more frequently. In fact, the internist is only now beginning to be fully awake to its frequency, and Osler has said that the fact that so many duodenal ulcers have been demonstrated by the surgeons in their clinics proves very clearly that the internist has been napping.

It approximates appendicitis in its frequency, and this has led to the belief that chronic appendicitis may have some part in the etiology. Patterson found that an analysis of his cases of duodenal ulcer, showed that two thirds had chronic appendicitis. This can readily be conceived, because the stomach, pylorus and duodenum are disturbed when there is an interference along the assimilative tract, as in chronic appendicitis, or Lane's kink, the pylorus closes in a spasm and the duodenum does not empty itself regularly, and in some cases it dilates, as shown by Lane in a recent paper, well illustrated by radiographs. The function of the first part of the duodenum is very much like that of the stomach. It has not the muscular action of the intestine, and when it is dilated, it acts much like the stomach except that it has no marked expulsive power. Its mucous membrane is thin and granular and it has no val-

vulæ conniventes. When it becomes impaired, neutralization of the acid chyme does not take place efficiently. The ulcer occurs in 90 per cent. of cases in the first one and a half inches on the anterior surface; this, Mayo thinks, is due to acid chyme ejected from the stomach to this point, and at this part also the blood supply is least, as shown by Wilkes in his splendid experiments, and in the demonstration of the enemic spot by Mayo. One of the cases that I have to report had her ulcer beginning at this point. I think also that toxemia and enemia, as well as acute bacterial invasion, are at times factors in the production of this ulceration.

We should not try to make the etiology too cut and dried, but think rather of the various possible causes in a patient predisposed by the anatomical arrangement of these parts and their functional activity. We must consider also those ulcers secondary to burns, tuberculosis and uremia, but the one I want to speak of particularly is the ulceration found so frequently in patients otherwise apparently well and which has a symptomatology resembling so-called dyspepsia, for which it is often treated.

This ulcer may be acute with sharp, severe symptoms, early perforation and hemorrhage, or may become chronic. With the acute perforation, we more frequently have a general peritonitis because there has not been the formation of protective adhesions such as we find in the chronic variety. After the perforation, if the patient survives, the ulcer tends to heal and there may be no further trouble from it.

It is very different with the chronic ulcer; it progresses slowly with many remissions, and the formation of many and thick adhesions which protect the general peritoneum, and at times glues the duodenum to one of the adjacent viscera; may even, at times, become adherent to the liver.

In a case recently operated, the duodenum, which was the site of a chronic indurated ulcer, dragged on the pylorus and was attached by adhesions to the posterior abdominal wall. There was a distinct kink in the pylorus, and the stomach was much dilated. Because of these adhesions, when perforations occur, there usually results localized lesions, walled-off abscesses in and about the region of the ulceration; even at times subphrenic collections of pus.

When hemorrhage occurs, it is usually from the pancreaticoduodenal artery and is rarely fatal.

In the symptomatology, hyper-chlorhydria stands out prominently in the early manifestations. It has been largely overlooked and treated as an entity instead of a symptom. Fenwick has said that chronic hyper-chlorhydria is not a disease but an expression of an organic lesion of some part of the digestive tract, or of associated organs that pour their secretions in. Along with this, are symptoms of dyspepsia, bloating after meals, eructations and, at times, pyrosis, and some kinds of food, as acids, coffee, pastry, aggravate the symptoms. Following this there is pain and it is this symptom that largely brings the patient to a realization that something is radically wrong, although at times a profuse hemorrhage may be the first alarming symptom. This pain, with its peculiarities, is one of the chief aids to a correct diagnosis. It occurs at a variable time after meals; anywhere from an hour to four hours. This pain, as Mayo puts it, occurs in the pit of the stomach and is generally relieved by eating.

Patients suffering from duodenal ulcer will often have near them, at night, a cracker, glass of milk, or soda, to take should the pain come, as it so often does—at night—sometimes waking the patient out of sleep. With this pain there is at times some little tenderness to the right and rigidity.

While hemorrhage is not to be looked or waited for in every case, I believe that at some time in the ulcer's course it will occur, and in some cases is a very marked symptom; the dark, tardy stools being the rule, with, at times, some hematemesis. Occult blood is often found, but is not of much diagnostic value because of the doubt, which is always present, of its origin.

Finney read a paper before the Congress of Surgeons on occult blood in stools and showed that you can have it with almost any abdominal condition, and, sometimes, without any demonstrable lesion.

The later symptoms are those of the complications following changes in the duodenum and adjacent organs; adhesions form and interfere with the normal emptying of the duodenum; it becomes dilated at first, and later, when the ulcer becomes large and indurated, its lumen is narrowed and the stomach dilated. All of the earlier symptoms are more severe and occur oftener and more regularly; vomiting is a more constant symptom, more distention of the abdomen is present, the



pain is more constant. All of the gastric phenomena associated with a spasm of the pylorus are aggravated, and the stomach washings show that food stays over-long in it.

In case of an old ulcer recently examined, there was increase of pain when the patient laid on abdomen, first observed when she was having a radiograph made, as she had avoided this position before. At the operation it was found that the ulcer had attached itself posteriorly and the prone position caused a pull upon the ulcerated area.

The symptom of free hydrochloric acid is not to be too much relied upon, as some of the cases (20 per cent.) have hypo-secretion. The most important symptom is pain, following eating, at a variable time, usually before four hours' time.

I do not think that we should look for relief from food in all cases, as it cannot be found in the history of every one, but pain with its accompanying gastric symptoms, is always present during the course of the ulcer.

In some cases the disease is not discovered until the patients are very much emaciated from repeated hemorrhages, or from the attacks of indigestion which have often been treated as dyspepsia. It is well to keep in mind always that about 80 per cent. of cases complaining of stomach trouble have no lesion there, but it is to be found in some other part of the alimentary tract.

While duodenal ulcer is found so frequently, duodenal cancer is very rare; for this reason there is not the same necessity for excision that there is in gastric ulcer, where 80 per cent. of the cases of cancer start as an ulcer.

When we can make our diagnosis early enough, medical treatment should be tried for several months. It is often hard to tell just when an ulcer is healed as in the remissions, the symptoms are very mild and there is a great tendency to recurrence. These cases are always benefited by rest and treatment.

The chronic calloused ulcer does not completely heal under treatment. The symptoms can often be allayed but recur again, often in the spring or fall. The surgical treatment of duodenal ulcer, is posterior gastro jejunostomy.

In selected cases the ulcer may be excised, but there is not the same necessity as in gastric ulcer as carcinoma is rare. If the anastomosis be made at the most dependent part of the stomach the food is passed there instead of the duodenum, as shown

in the accompanying radiograph; the jejunum pulls the stomach into somewhat of a funnel just at the opening. We may supplement the gastro enterostomy by closing the lumen of the duodenum by sutures, and it is especially wise to infold an active ulcer that shows signs of perforation.

The operation gives good results, and has a very low mortality, which is diminishing all the time. Complications have largely vanished since the posterior "no loop" operation.

Jejunal ulcer is rarely found, and when it occurs, it is usually due to some technical fault, such as an infected stitch or hematoma.

The cases in which there is vomiting after the operation, can often be entirely relieved by gastric lavage and the knee-chest position. These measures should be carefully tried before deciding that there is a vicious circle.

Because of the important part that chronic appendicitis and Lane's kink may have in the etiology, we should go over the symptoms carefully for evidence of earlier attacks of symptoms referred to these parts and should seriously consider exploration and removal of appendix or other exciting causes.

The two cases that I want briefly to report show the difference between the early symptoms before adhesions and secondary changes take place and the late symptoms of the old caloused ulcer, bound down by adhesions, and causing symptoms of obstruction and dilatation.

The first case: M. M., 19 years old, nervous temperament, enemic, has had for three years vague symptoms referred to the abdomen and epigastrium, such as belching and eructations, discomfort after eating. About a year and a half ago she began to have pain in the abdomen which became very severe. A diagnosis of appendicitis was made and the appendix removed. She was relieved for a while, but in May, 1912, developed acute pain, worse about two to four hours after eating, with symptoms of pyloro-spasm, but, at this time, there was no blood in the stools. On July 14, 1912, she had some hemorrhage from the bowel and complained of pain about three hours after meals, and while, at first, this was relieved by eating, later it became more or less constant and food did not relieve it. There were also eructations of gas, and blood was found in the stools. She was tender over the duodenum, a little to the right of mid-line, and had a point of tenderness to the left of the eleventh dorsal vertebrae. She was enemic and very much under weight. Gastric analysis was negative. Currants given

twelve hours before were not found in the washings. There was a mild degree of hyper-chlorhydria. A diagnosis of duodenal ulcer was made and at the operation, an ulcer, about one inch below the pyloric vein on the anterior surface, was found. It was irregular and slightly raised above the surface. There were no adhesions. A posterior gastro jejunostomy was performed with no loops. She had two attacks of vomiting following the operation, which quickly responded to gastric lavage. In a recent examination of the stools, no blood was found.

The other case to be reported was a patient of 59 years: M. J., had hip-joint disease when fifteen years old. Has had for years attacks of pain in epigastrium following eating and relieved by eating. The attacks became more frequent and severe, and latterly were accompanied by nausea and vomiting. The attack before the present one occurred three weeks ago, following a meal, pain coming on about one hour afterward; it lasted two days. The pain was very severe and cramp-like. Present attack began about three hours after eating lunch; had very severe pain in epigastrium, was tender all over the abdomen and, on the second day of the attack vomited some blood. We kept her under observation for ten days on special diet, but as soon as we attempted to give her solid food, there would be a return of the symptoms. There was also pain when she laid on her abdomen. There was marked splashing in the stomach, and a radiograph showed that it was very much dilated. Operation disclosed an indurated ulcer of the duodenum which was adherent to the posterior abdominal wall and had caused a distinct kink of the duodenum and a dilated stomach. A posterior gastro-jejunostomy was performed, using the jejunum just beyond the ligament of Treitz. She vomited once during the following day. The stomach was washed out and she has had no serious symptoms since.

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A SINGLE DOSE CURE OF A CASE OF ALOPECIA AREATA.—There is this satisfaction about diseases that manifest on the skin, that when they recover they recover obviously both to the patient and to his friends. Alopecia areata is emphatically not a disease that tends to spontaneous cure, and therefore a history recorded by Dr. E. de Keghel is the more interesting. It is that of a well-marked case of alopecia of years' standing, in which a fresh and satisfactory growth of hair on the bald patches followed the administration of a single dose of phosphorus 30. It is impossible to say with alopecia that the cure existed only in the imagination of the patient, and the case seems worthy of record.—*The Homœopathic World* (London), February 1, 1913.



**A COMMUNICATION RELATING TO THE MODE OF ACTION OF THE HOMŒOPATHIC REMEDY.**

DEAR DOCTOR GUERNSEY:

As long as knowledge is limited and the unknown is becoming ever vaster and vaster, there will be speculation and enquiry concerning the operation of natural forces; there will be effort to penetrate the veil of mystery and to uncover secrets hitherto obscure. No one can have hope or expectation that the last fact will ever be revealed. As men advance in knowledge, its horizon, like the end of the rainbow with its pot of gold, will ever be farther and farther away and our conception of its boundlessness be so much enlarged.

It would be very satisfying if we could explain a thousand things that we have learned how to use a very little but concerning the how and the why of their action we are ignorant. Why it is and how it is that any drug affects in a certain manner any part of the human body no one can tell. We know some phases of the action of ipecac and belladonna and a thousand other forces and can put our knowledge to profitable use. Why one agent acts upon the sympathetic causing vomiting or another agent acts upon circular muscular fibers causing them to dilate, is wholly mysterious.

When Hahnemann apprehended that drugs acted in accordance with the principle *Similia Similibus Curentur* he harnessed therapeutics for more valiant service to mankind than it had ever before rendered; but when he attempted to explain how and why it served the purpose he was over his head, the bottom was too far down.

I have read and heard many attempts at elucidating the *modus operandi* of the homœopathic law, but none of them has ever been entirely satisfactory. Newton and many of his pupils have tried to tell us how the apple falls but however learned the discourse, further explanation is welcomed.

Whether we can solve the problem by believing that the rule of selection is in accordance with "*Similia*" while the real secret of the cure is in accordance with "*Contraria*," through the primary and secondary action of the drug, will remain an open question, hotly contested.

About the best explanation of the action of the Law I ever heard was given by Prof. A. O. Blair to the class of the Cleveland Homœopathic College in 1870. It was an incident occur-

ring at the Ohio State Fair during a horse race. With many thousand people packed against the rope all around the course and the horses in spirited action a fine stallion ran away, freed himself from his driver and dashed furiously around the course producing intense consternation as he threatened at every point to dash into the human mass. That was a time for wise action on the part of the Master of the Course. Instead of arraying strong opposition in the face of the infuriated beast—"Contraria"—the man galloped *with* him in a *similar* manner, ever gaining upon him and drawing nearer and nearer until he was along side, running neck and neck and when the gate of exit was neared the man took the stallion gently and easily by the bit and safely conducted him out of the ring.\*

Yours fraternally,

O. S. RUNNELS.

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\*The same illustration, in effect, is used by Walter M. James, M. D., in his discussion of this subject in the *HAHNEMANNIAN MONTHLY*, February, 1913, p. 130.  
J. C. G.

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ARTIFICIAL FECUNDATION.—By Hirsch (*Berl. klin. Wchrschr.*, July 15, 1912).—The author considers that efforts thus far made show the feasibility of artificial fertilization in suitable cases, and that its execution depends on a scientific basis, and represents an operative procedure with strictly defined indications. The author's experience is concerned with sixteen cases, of which six were successfully treated, although in one abortion resulted in the ninth week. The fact that a failure resulted in the first seven cases is attributed by the author to a faulty technic, because in the succeeding nine cases a positive result was secured in six. The procedure is that advocated by Rohleder in most respects. The spermatic fluid is drawn up from a rubber condom with a dry sterilized syringe which should be warmed to 38 degrees cent. It is very important not to overheat the apparatus as the spermatozoa are more sensitive to excessive heat than cold. Only a few drops of the fluid are injected into the uterine cavity in order to avoid colic of the organ but the remainder of the material is injected in front of the cervix, a tampon inserted and the patient kept in bed for about a day. The patency of the cervical canal must always be previously determined and if stenosis is present a dilatation should be undertaken about a week previously. The retroflexion of the uterus must also be overcome and if the patient is anemic a previous injection treatment with sodium arsenite is indicated. The application is made directly before or immediately after a menstrual period, although the latter seems to be the more favorable time. If unsuccessful at the first attempt the procedure may be repeated although the author advises giving it up after the third session. Hirsch believes that if ten per cent. of all marriages are sterile and half of these cannot be treated by the usual methods, that at least one third will respond to the procedure which he advocates.—*New York Post-Graduate*.

## EDITORIAL

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### THE ETIOLOGY AND TREATMENT OF ARTERIOSCLEROSIS.

PREMATURE hardening of the arteries is a disease of increasing frequency. In these days when sanitarians and health officers are doing so much to improve the health of the community and at times, in their optimism, go so far as to prophesy the time when there will be no need for the physician, we see abundant evidence that the acute infectious diseases are rapidly on the decline. On the other hand, the degenerative class of disease is steadily on the increase and arteriosclerosis is one of the most important and most common of this class of disorders.

It requires but little knowledge of arteriosclerosis to convince one that the proliferation of connective tissue or the deposit of lime salts in the walls of the arteries is the *result* of some pre-existing abnormal condition. In an endeavor to discover the primary etiological factors in arteriosclerosis, it is necessary for us to bear in mind that arterial changes may result from any condition that entails wear and tear upon the blood vessels and that, even under normal conditions, with advancing years, certain alterations take place in the arterial walls. Before the age of puberty the elastic tissue develops up to a certain degree of firmness and this state, in a healthy individual, persists unchanged to about the fortieth year. By the beginning of the fifth decade the arteries begin to lose part of their former elasticity and, coincident with the loss of elastic tissue, there takes place an increase in the connective tissue of the intima and of the media. During the sixth decade, the deterioration of the walls of the arteries is usually quite evident and, in an anatomic sense, arteriosclerosis to a degree sufficient to produce noticeable symptoms is present with few exceptions. The physician, however, should be careful in explaining to the patient the nature and source of these symptoms, not to give the patient the impression that his condition is an unnatural one. In fact it is doubtful if it is ever judicious to pronounce



the case as one of arteriosclerosis to the layman, unless the changes in the arteries have progressed well beyond the stage that would be considered normal at the patient's age.

A word of warning is important in connection with the finding of calcified areas in the walls of the arteries. Many physicians look upon this condition as being present only in extreme cases of arteriosclerosis and are inclined to interpret calcification as being an evidence of the final stage of this disease. It is not our intention to make light of this condition, nevertheless it should clearly be understood that degeneration of the intima with the deposition of calcium salts may be present in the very beginning of arteriosclerosis and that the deposition of lime salts represents an effort on the part of nature to strengthen the arterial walls at these points of degeneration.

In considering the factors that predispose to premature arterial degeneration, heredity occupies an important place. Certain individuals inherit arteries that deteriorate rapidly under the strain entailed by overwork, infectious diseases, and by a variety of endogenous and exogenous toxemias.

Infectious diseases are responsible for sclerotic changes in the arteries in a large proportion of cases. Syphilis is probably the most important infection commonly responsible for arterial degeneration. Typhoid fever, diphtheria, scarlet fever, influenza, pneumonia and measles are all capable of effecting similar changes and it is now being recognized that even in childhood the signs of arterial degeneration may be found following what has been considered an apparently trivial bacterial infection.

The great group of diseases commonly known as metabolic or constitutional diseases, the most important of which are gout, obesity and diabetes, play an important role in the development of arteriosclerosis. In fact it is probable that, aside from syphilis, the metabolic diseases above referred to are the most important of all the etiological factors.

The arterial changes associated with diabetes are ordinarily recognized. The role of gout in the production of arteriosclerosis is not as thoroughly understood as the common-place statement made to patients by physicians, that their arterial degeneration is due to "uric acid" in the system, would seem to imply. As a matter of fact the true nature of gout is very poorly understood and it is by no means certain that uric acid is the substance that produces alterations in the structure of

the walls of the arteries. This statement which applies to typical gout, an arthritis associated with the deposits of urates, applies with even greater force to so-called "irregular gout." This latter condition, also referred to as the "uric acid diathesis," is designated by many physicians as the source of all human ills of obscure origin, and the zeal manifested in attacking "uric acid," which in many instances exists more in the mind of the physician than in the body of the patient, would be worthy of commendation were it exerted along more rational and more helpful lines. It is probably true that in these cases, some toxic substance of obscure nature and origin exists in the blood, and while we do not know what this toxic substance is, we do know that it is *not* uric acid.

Exogenous and endogenous toxins are certainly factors of great importance in the production of arteriosclerosis. Of the exogenous toxins, alcohol, tobacco and lead, are the most common. The susceptibility of individuals to these substances varies greatly, but their importance should always be borne in mind in dealing with this class of cases.

Of the endogenous toxins capable of producing degeneration of the walls of the arteries, those resulting from disturbances of the gastro-intestinal tract and from alterations in the glands of internal secretion, are most important. The enterogenous poisons are believed by most authorities to result from the effect of certain bacteria upon the contents of the intestinal tract, especially upon the proteid foods.

Of the poisons formed as the result of disturbances of the internal secretions, we have but scant knowledge. There are good reasons for believing that disturbances of the suprarenal glands and of the hypophysis cerebri are capable of producing arteriosclerosis. Certainly, such changes are commonly met with in acromegaly.

Over-exertion either mental or physical can be designated as the etiological factor in quite a large percentage of cases of arteriosclerosis. By some this is thought to be the result of pronounced variations in arterial tension, while others believe that excessive mental or physical work results in the overloading of the system with abnormal amounts of toxic material, the result of metabolic activity, and that it is the irritation resulting from these substances that produces arterial changes.

In considering the therapeutic management of a patient suffering from arteriosclerosis, it is evident that the etiological

factor at work in an individual case will be a valuable guide to us in instituting means for the amelioration of the condition and the prevention of further changes. In every instance it is important to bear in mind that a patient afflicted with arteriosclerosis has a smaller working capacity than a normal individual. It is as essential that such an individual should modify his habits of living and work to meet this change in his internal environment as would be the case were his external environment changed. This usually means a reduction in mental and physical work, as the conditions of the case may demand, and unless favorable conditions can be attained in this respect, permanent and satisfactory improvement is not likely to be brought about.

The question of diet is an important one and it is necessary for the physician to exercise a great deal of common sense in this matter. It has been the fashion for a number of years to interdict the use of meat in such cases. Von Noorden, whose studies of the effect of diet on metabolism have been very thorough and complete, states that the doctrine that meat favors the development of arteriosclerosis and that the patient can be benefited by forbidding meat, is without any foundation whatever. The idea that dark meat is bad for arteriosclerosis and that light meat is not injurious, is a fallacy much in vogue which has no foundation whatever in clinical experience. Most authorities have agreed that no specific diet for this disease can be laid down for every case. As a rule heavy meals are to be forbidden, all foods that tend to fermentation and the formation of gas should be interdicted and intestinal stasis should be carefully avoided. There are reasons for believing that the use of fruits, especially the juicy fruits, is of value in preventing intestinal fermentation and in aiding normal metabolic processes.

Tobacco, alcohol, strong tea and coffee should always be avoided. The use of carbon dioxide baths and the various electrical measures which tend to lower blood pressure and to aid elimination is advisable where such measures can be carried out under careful medical supervision.

During the last year or two, a great deal has been written regarding the value of radium therapy in arteriosclerosis. As to the true value of radium baths, the drinking of waters containing radium, etc., it is too early to make any positive statement. We are still in the midst of a wave of radium enthusi-



asm and the very exaggerated statements made regarding therapeutic value of this substance of which so little is understood, reminds us very much of the similar waves of enthusiasm that were manifested in regard to the use of galvanism, faradism and later of the X-rays and other electrical measures. As a matter of fact there seems to be little substantial reason for believing that the use of radium in any form is capable of benefiting patients suffering from arterial degeneration.

In regard to the medicinal treatment of arteriosclerosis, it can be positively stated that no remedy of any specific value has as yet been discovered. Von Noorden warns against the use of the thyroid extract and also states that the iodides so frequently prescribed by the members of the dominant school are, in the vast majority of cases, incapable of producing any beneficial results and quite often do harm. To quote his own words, "At times the administration of iodides brings about destruction and absorption of the thyroid gland with the development of acute hyperthyroidism and severe glycosuria."

"The practice which has recently come into vogue of ordering the iodides in ordinary senile arteriosclerosis and for the relative senile symptoms in general, is particularly unwise and shows an utter lack of judgment on the part of the physician." There are a number of remedies at the disposal of the homœopathic prescriber that experience has shown to be of value in ameliorating the symptoms and in preventing the development of further arterial changes. Among those that have commonly proven useful in this respect, may be mentioned aurum, plumbum, argentum nitricum and baryta carb. We cannot, however, too strongly insist upon the strictly symptomatic prescribing according to the symptoms presented by the individual case as the essential point to be borne in mind in selecting a remedy for these patients.

G. H. W.

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#### AN APPEAL TO THE AMERICAN MEDICAL ASSOCIATION TO MAKE A SCIENTIFIC INVESTIGATION OF HOMŒOPATHY.

At the last session of the American Institute of Homœopathy a committee was appointed to present to the American Medical Association a proposition for a joint investigation of the merits of the homœopathic method of drug selection. Dr. H. D. Schenck, of Brooklyn, N. Y., was made chairman of this committee and has recently forwarded to the president and

secretary of the American Medical Association the following communication:

GENTLEMEN:

In 1908 the undersigned were appointed a committee by the American Institute of Homœopathy to present to the American Medical Association on behalf of the homœopathic profession of the United States a proposition for a *joint* investigation of the scientific merits of the method of drug selection expressed by the formula "*Similia Similibus Curentur*."

The committee has presented the matter to individual members of the House of Delegates, but we believe the matter has never been regularly presented to the House or to the Association itself, as a whole. We request that you bring the matter up for consideration and early action by both. For the following reasons it seems to us a subject worthy of your serious thought:

This rule has governed the selection of drugs in the treatment of diseases by a considerable number of medical practitioners for over a century. We feel that the time has come when this formula should be brought before the whole medical profession, carefully investigated by modern scientific methods and a determination made of the exact value of this method in the practice of medicine. We seek this:

First. Because the voluntary testimony of a large number of physicians who do not understand the correct application of this method indicates their desire to make use of it.

Second. Because a large number of men who attempt its use ought to be able to get a better understanding of its true significance.

Third. Because we believe a large majority of the medical profession would have their usefulness and their power to benefit the sick largely enhanced by a thorough knowledge of this method.

Fourth. Because we believe that suffering is lessened and sickness more speedily and comfortably terminated through drugs administered according to the rule of similars.

Fifth. Because we feel that a careful investigation of this subject belongs to the whole medical profession and not to any single branch of it.

Sixth. We feel that such research regarding the formula of similars is desirable. Because the exactness of modern science with the present means of investigation, together with the accurate observation of the subjective as well as the objective symptoms, make it expedient to investigate the action of

many drugs coming into use at the present time, as well as to re-examine those long proven.

For the above various reasons we pray that your organization appoint a committee of five to meet a like committee from the American Institute of Homœopathy to discuss this subject with a view of attempting a demonstration of the accuracy of the theory of similars, or of proving its falsity.

It seems to us that its joint investigation should be made under the auspices of some research laboratory like the Rockefeller Institute of New York or the McCormick Institute of Chicago. These institutions have the experts necessary for such a test; with trained eyes they could follow its course from start to finish. Whether the result of the particular investigation should prove satisfactory or not, the effort would not be wasted because a list of drugs in common use among the members of your Association as well as ours can be selected for this study of their physiological action. These accurate observations would be of permanent value to both schools.

After careful investigation of the effects of these drugs in different strengths upon the human body, as well as observing their poisonous effects in animals, an extensive trial of their therapeutic efficacy should be made in some of the large public hospitals to test the action of these remedies in exemplifying this theory of drug administration.

In recent years every effort has been made to unite the medical profession. A large number of legal practitioners is kept from affiliation because of its belief in a method of drug selection, the truth of which is questioned by the majority. Let us make a thorough test of this hypothesis. If it be proven true, humanity will be benefited by the enlarged and improved armamentarium of all physicians; if it be disproven, the last obstacle to medical union will have been removed.

To the end, therefore, that the truth be established, let us put this theory to the test proposed. Naturally we feel confident that the principle will be established, but in the interest of mankind we request you to join with us in a scientific demonstration of the truth or falsity of the theory of cure promulgated by Samuel Hahnemann.

Respectfully submitted,

(Signed) HERBERT DANA SCHENCK, M. D., Brooklyn.  
J. B. G. CUSTIS, M. D., Washington, D. C.  
WM. RUFUS KING, M. D., Washington, D. C.  
ROYAL S. COPELAND, M. D., New York.  
FRANK RICHARDSON, M. D., Boston.  
ALONZO C. TENNEY, M. D., Chicago.  
FRED W. WOOD, M. D., Chicago.  
BENJAMIN F. BAILEY, M. D., Lincoln, Neb.



This is a frank and earnest appeal to the largest organized body of American physicians to seriously and scientifically investigate the value of homœopathy in the treatment of the sick. It is remarkable that in the more than one hundred years that have elapsed since the introduction of homœopathy into the practice of medicine, no investigation of its merits, that could in any sense be termed scientific or unprejudiced, has ever been made by the great majority of the medical profession.

There are, no doubt, many members of the homœopathic profession who will take exception to this action on the part of the committee representing the American Institute of Homœopathy, because they believe that the dominant school of medicine is both unwilling and incapable of testing fairly and scientifically, the claims of homœopathy. Whether this is true or not remains to be seen. No reply has been made as yet to the committee representing the American Institute of Homœopathy in this matter and we would not attempt to prophesy what attitude the American Medical Association will take toward the proposition. If honestly and carefully carried out, such a test would be of inestimable value to every practitioner of medicine and, in our judgment, would lead to the recognition by the profession as a whole, of the true value of the work of Samuel Hahnemann and of his followers. To carry the test out in any other spirit, would make the investigation a fraud in the worst sense of the term and would bring the dominant school under the condemnation of every scientific physician, as well as every fair-minded layman, throughout the civilized world.

G. H. W.

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#### REPORT OF THE BUREAU OF MEDICAL EDUCATION AND LICENSURE OF THE STATE OF PENNSYLVANIA.

THE annual inspection of the medical colleges of the State as provided for by the Medical Act was made February 13th, 14th, 15th. It was gratifying to note that without exception each institution has shown very material advancement over that exhibited last year; three have largely improved their facilities for clinical teaching, one having added a new hospital building entirely owned and controlled by the school, two have equipped entirely new laboratories, one has rebuilt and mod-

ernized its dissecting room, two have added new and modern teaching museums. One having made very material advances in furnishing the new museum with fresh and well classified specimens, new and modern apparatus and appliances are in evidence in all directions. Great activity was noted in the hospital wards; small classes in charge of instructors were found actively at work in all directions.

The number of full time paid members of the faculty was found universally increased; in all instances fulfilling the minimum number of six demanded by advanced requirements; in a number of cases as many as twelve.

Great improvement is noted in the teaching in the practical anatomical work, especially with reference to the study of applied anatomy. Several of the schools have arranged for new and expert teaching in preventive medicine.

All the schools have found it easily possible to conform to the rules of the Bureau regarding the number of obstetrical cases to be attended, the assistance at operations, the giving of anesthetics and the witnessing of post-mortems: the student bodies and the faculties both regard this new requirement with approval.

Three of the medical colleges of this State are associated with universities and are well equipped to teach the subjects of chemistry, biology, physics and a modern language which will be required after January 1st, 1914, in addition to a four-year high school course as preliminary to entering a medical school; the independent medical schools not having such an affiliation are arranging courses of instruction in their own institutions covering these subjects. These courses will all be begun with the advent of the coming fall session. Thus the Pennsylvania medical schools have all cleared the way for the great steps in advance in medical education to become effective with the classes of 1914.

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THE TREATMENT OF ACUTE CHEST CASES. *By Giles F. Goldsborough, M. D., Physician to the London Homœopathic Hospital.*—Dr. Goldsborough speaks of the value of lycopodium in the treatment of acute chest cases. He states that lycopodium is indicated with moist rhonchi and great prostration. [There cannot be any doubt however that lycopodium is very highly curative where the patient is suffering intensely with shortness of breath—in fact lycopodium is one of our best remedies for dyspneic states. It soon relieves orthopnea as well.]—*British Homœopathic Journal*, March, 1913.

## GLEANINGS

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TREATMENT OF VASOMOTOR NEUROSES.—There are a number of vasomotor and trophoneurotic affections, some simulating surgical affections so closely as to lead to the performance of unnecessary, indeed harmful, operations; others calling, in their ultimate development, for amputation—all dependent on angiospasm or angioparesis. Clark (*American Journal of Obstetrics*, November, 1912) states it is now generally accepted that the vasomotor nerve passes to both the arteries and the veins; that the medullary vasomotor center exerts a toning function, which maintains a state of medium vascular contraction, modified through the blood composition and reflexly excited or depressed; that excitory depressing fibers exist independently of each other in all sensory nerves, stimulation of excitory fibers causing rise of blood-pressure, and being elicited far more frequently than vasodilatation. When vasodilatation is obtained the subject is often in a state of general fatigue, the highest type of depressing or vasodilator action being seen after section of the sympathetic, as best typified in ear redness, heat, and swelling. If the entire spinal cord is divided the temperature rise in the extremities is sudden and marked. Stimulation by way of the vasomotor center naturally increases the work of the heart, thus setting up a vicious circle.

Acute circumscribed edema, called Quincke's disease, in part a familiar malady, has no predilection for sex or age. The edemas may be submucous, subcutaneous, or articular, including tendon sheaths. The onset is acute, at times with prodromal lassitude, chilliness, nausea, etc. The edema is usually single, painless, sharply circumscribed, elastic without marked pitting, and may be red or white. Exceptionally a whole part may be swelled, as in the leg or forearm. The lips, eyelids, and cheeks are seats of predilection, though the swelling may appear in any part of the body, least commonly in the scalp. The upper air and food passages are very frequently involved, and the resulting obstruction may call for tracheotomy. One third of the fatal cases perish from laryngeal obstruction. Fugitive swellings of tendon sheaths, perhaps entirely unaccompanied with superficial swellings, are typical. The location in joint cavities induces a condition known to surgeons as intermittent joint dropsy. It is almost peculiar to the knee, one or both. The renal symptoms appear as paroxysmal hemoglobinuria, polyuria, and albuminuria. Headache, drowsiness, and vertigo represent central symptoms. One attack of swelling may last for one to several days. The intervals between attacks vary from weeks to years. At times there is a periodicity of recurrence.

Typical urticarial lesions are hot, red, and itchy, while typical circumscribed edema is pale, cool, and devoid of abnormal sensations; but these qualities are sometimes interchanged. The edema may be of the autotoxic



or infectious origin, or familial. Milroy has described 22 individuals in six generations in which existed from birth a solid edema of both legs below the knees, pitting on pressure, without any special inconvenience or any progressive increase of the disease.

Erythema nodosum occurring in large, firm, circumscribed swellings on the limbs should in theory be somewhat like Quincke's disease. As a matter of fact, however, it is readily distinguished, because it does not present a great variety of type, and even in doubtful cases the color-play seen during the subsidence of a lesion, which resembles that in a bruise, and is due to some extravasation of blood, is like nothing seen in Quincke's disease.

As to the treatment of Quincke's disease, attention to diet and the state of the stomach and bowels is of major import. Faradism is much preferred to any other current, and warm, dry, or moist baths are preferable to cold applications.

Raynaud's disease may be considered as a chronic vasomotor neurosis attended by vascular changes without organic disease of the vessels, chiefly seen in the extremities, but observed in the abdominal viscera.

Cassierer has shown that the largest incidence is in the first five years of life. It may rank with hereditary and familial diseases. The early stage is vasomotor, including sensory symptoms and trophic disturbances, the later necrotic represented by exfoliation of the devitalized area.

The first or vasomotor stage exhibits two types, viz., local syncope and local asphyxia. The first consists of a sudden blanching and coldness of the fingers, toes, tips of ears, or nose. There is marked lowering of temperature. The sensory troubles include both paresthesia and pain and vary greatly. The sensations may precede the vasomotor disturbances, and are usually aggravated when the latter appear. There are no true motor disturbances, only a sort of clumsiness.

Local asphyxia or cyanosis naturally shades into the local syncope. When well developed it is characterized by dark discoloration, which may be continuous or marbled. Under pressure the dark areas become white and remain so for a considerable period. There is swelling and lowered temperature. This is not due to ordinary edema, but is a vasomotor phenomena akin to angioneurotic edema. There is an ultimate tendency to localized persistence of asphyxia or syncope. In some cases attacks of asphyxia or syncope occur with no disposition to lead to gangrene. In others gangrene supervenes a few days after the earlier symptoms, and this usually results fatally. Usually there is but a single attack during the cycle of invasion, which is continuous and passes on to gangrene in the course of some ten days. There seems an undoubted association between malaria and Raynaud's disease, not only as shown by personal histories, but perhaps by the marked periodicity of some cases. Raynaud's disease has often developed in people who are victims of some chronic disease, such as tuberculosis, syphilis, or chronic nephritis.

As to treatment, general hygiene, attention to the condition of the blood and the nervous system, avoidance of local trauma, and above all the avoidance of overexertion, are indicated. Hydriatic procedures have been used extensively. Ice to the elbow sometimes overcomes the vascular spasm of the fingers. Gentle massage and oil rubbings seem to give relief. Ano-

dynes are often called for, and the coal-tar derivatives are sometimes serviceable. Gangrene is managed on the let-alone plan.

Erythromelalgia is a chronic vasomotor disorder characterized by pain, flushing, and heat, usually of one or more extremities or other parts of the body, made much worse by putting the part involved in the dependent position. It is extremely rare, is most frequently caused by exposure to wet or cold, or both, and by overexertion. Tenderness, pain, and redness of the parts are the cardinal symptoms. The pain is characteristic, tending to increase progressively until it becomes almost unendurable, especially aggravated by gravity, warmth, or overexertion. Hence posture and cold are instinctive remedies. Pain as a rule precedes the congestion, sometimes even for days or weeks. Swelling is not constantly present; if so it is transitory, constituting a sort of crisis, and is often associated with a local rise in temperature. Painful sensations are usually felt in the feet and toes. The hands are attacked about one half as frequently, and in a fair proportion of cases all four extremities are involved. Systematic hydrotherapy probably holds out some hope of relief, as do galvanic and local baths. Theoretically neurectomy is indicated to put an end to pain. Once or twice the desired result was obtained, but in other cases there was failure, and in one case after extensive neurectomies gangrene developed and amputation became necessary.

Under the term vasomotor ataxia are classed a variety of affections sufficiently familiar to the medical practitioner. The condition is attributed to the inherent instability of the vasomotor system. The manifestations often appear in a neurasthenic, neuropathic, or hysterical substratum. Traumatic neuroses become intelligible in part from this standpoint. In the climacteric in women vasomotor ataxia is known to be commonly present. A similar condition is produced by alcohol and tobacco. Attacks vary greatly in onset, duration, and interval. Factors which determine attacks vary greatly. They may consist of mechanical, chemical, or thermal irritation, drug action, etc., aside from psychical causes. Such phenomena as "nervous chills," fainting attacks, "rushes of blood," vertigo, etc., are familiar examples. Crises of colic and diarrhea, as if from angiospasm in the region of the mesenteric arteries, profuse rhinorrhea, crises of hay-fever, inexplicable congestions of the conjunctiva, are familiar examples of paroxysmally occurring vasomotor ataxia. Intense headache may be caused by congestion of the sinuses. A characteristic subjective feeling in cerebral hyperemia is one of dread and insecurity. Cerebration becomes difficult, and the patient thinks he is losing his mind. Vertigo is present at times. In some cases the meningeal syndrome develops. Cerebral anemia is much less significant as a manifestation of vasomotor ataxia.

Another set of manifestations is seen chiefly in the retina—transient blindness and hemianopsia.

In the abdomen the phenomena are vasodilator rather than vasoconstrictor. Pulsation of the abdominal aorta associated with violent pain is very common in women, and is usually demonstrable objectively. Attacks occur in crisis. Numerous digestive disorders coexist. The crises end with vomiting. The internal congestion is usually accompanied by surface anemia, often associated with eruptions of macules and wheals, purpura, edema of the feet, or sweating of the hands. Aside from these crises much

so-called nervous dyspepsia belongs in this category—the kind which comes and goes without apparent motive. Pseudohepatic colic not infrequently develops.

In the extremities the functional intermittent limp due to angiospasm of the lower extremities is characteristic.

This condensation of Clark's admirable summarization of a somewhat abstruse subject seems desirable from the surgical standpoint, since not only may needless operations be avoided by some knowledge of this subject, but many affections which the surgeon sees will at least be given a name and spared a fruitless medication. Even a distinction from infective inflammation is not always as simple as might seem, and must at times depend upon a careful history, at others upon the abrupt onset and transitory nature of many of the manifestations; again upon a complete examination covering temperature, pulse, blood picture, urine elimination, and study of all the existing symptoms. Osler has long since pointed out the angio-neurotic nature of certain abdominal crises such as closely simulate obstructive or perforative lesions; these from their nature are likely to be self-limited and call not in the least for surgical intervention.

Therapeutics applicable to the various conditions described may be summarized by a careful, nay rigid, attention to all the elements which make for the most perfect health possible for the individual. Particular attention should be paid to a possible gastroenteric source. There is no medicine which seems of especial avail. For the relief of the accompanying pain neurectomy has apparently been futile. The prognosis even for life is not always favorable; for permanent cure it should always be guarded.—*Editorial, Therapeutic Gazette.*

FURTHER CONTRIBUTIONS TO OUR KNOWLEDGE OF THE PERNICIOUS VOMITING OF PREGNANCY.—Williams in the *Glasgow Medical Journal* for December, 1912, reaches these conclusions:

1. The underlying factor in all cases of vomiting of pregnancy is probably an imperfect reaction on the part of the mother to the growing ovum.
2. In most cases this is only a predisposing cause, while a reflex or neurotic influence is the exciting factor, and cure usually follows its removal.
3. Williams still holds to the classification of reflex, neurotic, and toxemic vomiting. Of these the neurotic is the most and the reflex the least frequent type, while the toxemic is the most serious.
4. Pronounced toxemic vomiting is accompanied by characteristic lesions and profound changes in metabolism.
5. The significance of a high ammonia coefficient is not specific. It may be a manifestation of toxemic vomiting, of starvation following neurotic vomiting, or of an acidosis due to various causes.
6. It should be regarded merely as a danger-signal, while the differentiation between the various types is possible only after careful clinical observation. If improvement does not promptly follow appropriate treatment, the existence of toxemic vomiting should be assumed and abortion promptly induced.
7. In the absence of genital lesions, a low ammonia coefficient indicates neurotic vomiting, which can be cured by suggestion and dietetic treatment, no matter how ill the patient may appear.



8. In primiparous women vaginal hysterotomy is the most conservative method of emptying the uterus. Nitrous oxide gas or ether should be used in preference to chloroform for anesthesia.

A NEW TREATMENT OF TUBERCULOSIS.—Friedmann (*Dtsch. Med. Wochenschr.*).—The theoretical basis of the doctor's method consists in the hypothesis that the tuberculosis antigens reside in the bodies of the tubercle themselves, and that the most promising method of treatment consists in the injection of the living bacilli themselves. All the tuberculins have this quality in common, that they contain the bodies of tubercle bacilli more or less comminuted and more or less altered by the process of sterilization. Besides the antigens, the tuberculins also contain considerable quantities of toxins; an obvious drawback from Friedmann's point of view. The doctor, therefore, sought to find a modified tubercle bacillus, rich in antigens but non-virulent and free from toxic substances. Such a strain of tubercle bacilli he thinks he has found. In 1903 he and Piorowski isolated a tubercle bacillus from the body of a turtle in the Berlin Aquarium. At the time they believed this to be a special variety of the bacillus, since, while virulent for cold-blooded animals, it was entirely innocuous for warm-blooded ones. Further investigation has, however, led to the view that the water of the aquarium had become contaminated with human tuberculous sputum and that these turtle bacilli were human tubercle bacilli modified by passage through a cold-blooded organism. With this and similar strains of tubercle bacilli, Friedmann has made a vaccine, from the use of which astonishing results have been reported. The living bacilli are injected intramuscularly, a local induration resulting which is absorbed in the course of a few weeks. If, as rarely happens, an abscess forms, the injection is without therapeutic effect. This accident can be avoided by giving alternate intramuscular and intra-venous injections. Up to the present, some 1,200 patients have received the treatment, one or two intramuscular injections usually sufficing. Soon after the first injection obvious signs of improvement are said to be observable, in all varieties of tuberculosis. Twelve cases of joint tuberculosis, some of them very severe in type, were healed promptly and entirely. Pulmonary tuberculosis uniformly shows prompt amelioration of all the symptoms. The first to go are usually the night-sweats; pain, cough, fever, etc., disappear later. Renal and bladder tuberculosis also do well. Cutaneous tuberculosis offers the greatest difficulties to the treatment on account of the over-sensitiveness to the injections that usually accompanies it. By means of the combination of intravenous with intramuscular injections, good results may also be obtained in this form of tuberculosis. The injections are given in the immediate neighborhood of the infected area. Good results were uniformly observed in lupus of the mucous membranes. After it had become certain that the injections were quite free from danger, the doctor began to inoculate children exposed to a tuberculous environment, the injection sometimes being given immediately after birth. All the 335 children, hitherto inoculated, bore the injections without ill result and have so far remained free from scrofula.

Some of the most eminent of the Berlin clinicians confirmed Friedmann's claims. Thus Erich Mueller reported five cases of grave bone tubercu-

losis, in three of which the injections of Friedmann's vaccine led to a complete cure. In the other two, abscesses formed at the site of injection. Schleich stated that he had lost his early scepticism, regarding the treatment, after seeing a number of cases of surgical tuberculosis recover without operation. Katzenstein had had the same experience. Karfunkel confirmed Friedmann's statements in every detail. He had treated 450 cases, including all varieties of tuberculosis, with uniform success. In 200 cases of pulmonary phthisis, not a single one failed to show improvement. Kuester was equally enthusiastic and considered Friedmann's vaccine at least equal to that of Jenner in importance. Blaschko reported a case of cutaneous tuberculosis that had previously resisted all methods of treatment, including tuberculin, but which appeared to be yielding to the new vaccine. Citron spoke of the theoretical justification for Friedmann's method. Goldberg had seen 23 cases of pulmonary tuberculosis recover completely under this treatment.

Three questions have been propounded, which Friedmann has not answered. They were:

1. What is the dosage of the new remedy, and when will it be made accessible to the medical profession? (Bier).

2. How do the tuberculin reactions behave in the cured cases? (Meyer),

3. Why do abscesses sometimes follow the injections and how can a cure take place without the occurrence of reactions? (Wolff-Eisner).—*Charlotte Medical Journal.*

THE USE AND ABUSE OF THE THYROID IN OBESITY.—Jump states that formerly, owing to the lack of standardization in the preparations of the gland on the market, there was a considerable amount of confusion, even among physicians, as to its proper dose.

From the nature of this agent a putrefactive change may take place in it, and to this may be given the credit for some of the evil effects seen in the administration. Therefore the thyroid must be considered a powerful and dangerous remedy for two reasons: First, because of its marked tendency to injure muscles; secondly, because of its indeterminate action on the heart. The gland is a dangerous agent, and so are morphine and the coal-tar analgesics; none of these can be used carelessly nor in big doses, nor by the laity without supervision. Indeed, any useful drug may become harmful if abused. But in spite of the results which may occur, Jump believes there is a distinct indication for thyroid feeding in certain cases of obesity. It is in the endogenous or constitutional or thyrogenous obesity, where there is a small or inactive thyroid and poor catabolism, that it is most useful. It may also be given, with care, to the obese individual who is too fat to exercise, in order to reduce his weight to a point where he may exercise. Because of its diuretic action and its effect in checking the progress of arteriosclerosis and its destructive action on effete products, it ought to be of peculiar value in cases of interstitial nephritis in which the patients are too fat. He has had under his care, for some time, two such men, who have been kept in fairly good condition by this treatment.

It is well to begin with small doses of a fresh preparation of the dried gland, one half to one grain three times a day, and gradually increase it, being watchful for the first signs of intolerance. The diet must contain an

increased quantity of proteids, in order to save the tissue proteid, and a decreased quantity of carbohydrates to prevent glycosuria. While exercise may be dispensed with (the catabolism produced by the gland taking its place), it is valuable, in that it trains the patient in this important particular. It is necessary, of course, that the patient be under constant observation; he must not be allowed to use the remedy without advice. If, during its administration, the pulse rise above 100 and the patient complain of breathlessness and weakness, it should be stopped at once and small doses of arsenic given until the condition is relieved. It may then be started again at a smaller dose. When the treatment is stopped the patient may relapse into his former condition if, at the same time, he relax in his diet and exercise; but this same result obtains in any other cure. Most of the cases will require periodically recurring treatments, just as is the case in myxedema and cretinism.

In conclusion, Jump states that while this remedy must be put in the dangerous class, he can quote Sajous, who has said of thyroid in another relation, "There is no agent at our disposal whose effects can be controlled more accurately, if watched, and fresh preparations used."—*Penn. Med. Jour.*

THE TREATMENT OF HEART DISEASE IN CHILDREN.—Mackenzie in the *Lancet* of January 4, 1913, writes of some manifestations of a healthy heart in the young which were frequently taken as indications for treatment. He said that as a first step to treatment it was necessary to have a clear idea of what one is going to treat, and the significance of this was brought out by considering what was the essential purpose of a medical examination. This was to determine the prognostic significance of certain phenomena and their bearing on the presence or likelihood of heart failure. It would be shown that this purpose frequently failed in dealing with such phenomena as irregular action of the heart and murmurs. The absence of reliable data had hitherto militated against the obtaining of a prognosis based on trustworthy grounds or a basis for an intelligent therapy. A description was given of the means by which this deficiency could be made good, and was illustrated by recent observations on the mechanism by which certain irregularities were produced and their prognostic significance. The bearing of a functional murmur on the heart's efficiency was discussed, and it was shown that certain irregularities and functional murmurs were perfectly compatible with healthy hearts. The relation of functional murmurs to heart failure was considered, and attention was drawn to the fact that the cause of the murmur was not the cause of the heart failure, but that the heart failure was invariably due to the impairment of the heart muscle.

The means by which impairment of the heart muscle could be detected was shown in many cases to depend not so much on the physical signs as upon the due appreciation of the functional efficiency of the heart muscle. The signs by which one could recognize the functional efficiency of the heart had not received that consideration which was their due, and it was on this account, and also on account of the imperfect teaching of cardiac symptomatology, that a mistaken conception of the meaning of these phenomena was so widespread. Evidence of these misconceptions drawn



from personal experience was offered, showing how normal phenomena had been taken as indications for treatment, and as a consequence how cardiac therapy had become burdened by many useless drugs and methods. — *Therapeutic Gazette.*

TREATMENT OF SNAKE BITE BY POTASSIUM PERMANGANATE.—Bannerman investigated the treatment of snake bite by permanganate of potassium in consequence of representations made by Sir T. Lauder Brunton to the Government of India. In the first series of experiments, natural conditions of biting were imitated as closely as possible. The dose was given by the actual bite of the cobra or daboia, and it is noted that, after having bitten, the cobra remains attached to his prey for an appreciable time, while the daboia darts with incredible rapidity and releases its victim instantly. The latter occasionally fails in its stroke. These experiments showed that:

1. A dog bitten by a cobra cannot be saved by the local application of powdered potassium permanganate rubbed in after free incision of the bitten place; nor by a similar application of a solution of the powder.
2. It may be saved by the immediate subcutaneous injection of ten c.c. of a five per cent. solution of the drug; but that this solution is so strong as to act as an escharotic.
3. If this treatment is delayed for even two minutes, it loses its efficacy.
4. A dog bitten under natural conditions by a Russell's viper, daboia, cannot be saved by the drug, however applied.

Another series of experiments was carried out, in which an attempt was made to inject the drug intravenously, but it was found that the intravenous injection of even forty c.c. of a half of one per cent. solution of potassium permanganate caused death from intravascular clotting. Next, the minimum lethal doses of the venom of these snakes for dogs were determined. It was also determined that the venom of both in solution was neutralized in vitro by half its weight of potassium permanganate in five minutes. Then it was shown that even four times the amount that serves to neutralize the venom in a test tube will not with certainty prevent fatal poisoning in an animal which has received ten minimum lethal doses. It was also found that crystals of potassium permanganate, when rubbed into incisions in a dog's leg, produce extensive ulceration, and that, when combined with the local action of daboia venom, they may cause even necrosis of the small bones. Bannerman remarks: "The conclusions as to the action of potassium permanganate powder on small doses of cobra venom injected just under the skin appear to be that this treatment is of some little use under these highly artificial conditions. It must be remembered, however, that a snake does not deposit its venom under the skin, but, striking as it does with its fangs at right angles to the skin, the poison must usually be placed well below the fascia of the part, and therefore further removed from the applications of a chemical antidote. With regard to daboia venom injected just under the skin the results are very similar to those obtained with the venom of the cobra, i. e., that under such artificial conditions the treatment by free incision and rubbing with powder of potassium permanganate is of some little use. As a practical measure for employment after actual snake bite it appears to be of no use whatever."—*Indian Medical Gazette.*

STUDIES OF THE RENAL FUNCTION IN RENAL, CARDIO-RENAL AND CARDIAC DISEASES.—By Dr. L. T. Rountree and Dr. R. Fitz.—These investigators have studied the results of various renal functional tests in a series of fifty-seven cases suffering from nephritis and cardio-renal diseases. The tests employed by the authors were the phenolsulphonephthalein, lactose, salt water potassium iodide and also the accumulation in the blood of incoagulable nitrogen. Their conclusions are stated as follows:

1. *The functional condition of the kidney can unquestionably be determined much more accurately by the use of these tests than through ordinary clinical studies alone.*

2. The phthalein test is of great prognostic and diagnostic value. For general use it is of more value prognostically than any other single test; diagnostically, also, it is of value in cardio-renal diseases for determining the relative responsibility of the heart or kidney for the clinical condition.

The lactose test is of great value diagnostically in determining the existence of abnormal renal function. The significance of its delayed excretion is obscure. The suppression of the excretion of lactose may be of considerable value prognostically.

The salt test if considered alone is of no value, since it is subjected to so many extra-renal factors. When considered in conjunction with clinical and other functional studies, it may prove of some value diagnostically and prognostically.

The amount of water excreted in cases of pure nephritis, in response to sodium chlorid stimulation, may be of diagnostic value.

The potassium iodid test is of little value diagnostically or prognostically.

The marked accumulation in the blood of incoagulable nitrogen in cases of nephritis, when present, is of considerable prognostic value.

3. It is possible in cases of cardio-renal disease with varying degrees of chronic passive congestion and nephritis to determine which factor is of greater importance in the causation of the clinical picture encountered. This can be done most readily by repeated phthalein tests, while the determination of incoagulable nitrogen in the blood may also be of value. The lactose and iodid tests are of no value in this respect.

4. It is possible by these tests, to diagnosticate the presence or absence of impairment of renal function in cases in which clinically nephritis is suggested. In this respect the lactose and phthalein tests are of most value.

5. Before feeling convinced of the justifiability of drawing conclusions relative to the involvement of the vascular or tubular functions under pathological conditions, we feel that a much deeper knowledge concerning the physiology of the excretions of these various substances studied is necessary.—*Archives of Int. Medicine, March, 1913.*

INDICAN SUPERSTITIONS.—Dr. A. W. Peters has treated in a very interesting way the subject of indicanuria and has pointed out that many of the popular ideas regarding the significance of indican in the blood are founded on erroneous ideas. He lays down as an axiom that all urine contains indican, and advances the statement that without a knowledge of the diet in use; and of the amount of physical and mental exercise taken it is absurd to interpret as pathological the presence of indican in excess. Quoting Barr's recent important monograph as his authority he says that the

indican test of intestinal intoxication is a superstition. Metchnikoff's lacto-bacillin, milk cereal diets, etc., have no effect upon the production or excretion of indican. Another medical myth is that of gastro-intestinal autointoxication.

**TONSILLOTOMY VS. TONSILLECTOMY.**—There has been considerable discussion in medical journals of late as to the relative advantages and disadvantages of tonsillotomy and tonsillectomy. The following summary of the disadvantages of them in an editorial in a recent issue of the *Therapeutic Gazette* presents a brief summary of facts that are now available.

"The disadvantages of tonsillotomy are: (1) The initiation of an infection, whether manifesting itself as tonsillitis, lymphadenitis, or both. Such sequelæ are more likely if a very free and deep removal has been performed than if only a moderate amount of the tonsil has been removed. (2) Recurrence of the trouble for which the operation was performed, except in the case of voice troubles, when recurrence is no more probable than after tonsillectomy.

"The disadvantages of tonsillectomy are: (1) A risk of serious or even dangerous hemorrhage at operation. (2) A risk of harmful deformity supervening later; the deformities most likely to cause harm are adhesion of the posterior faucial pillar to the posterior pharyngeal wall, and overgrowth of the plica triangularis. (3) A risk of voice troubles supervening later, even without any causative deformity. To any patient who requires operation for some other reason, who has never had any voice trouble, and whose livelihood or occupation depends on the use of the voice, tonsillectomy should be urged with caution.

"Thus it would appear that tonsillectomy is the more dangerous operation. But with the single exception of voice troubles, it is more likely to permanently cure the complaint for which advice is sought, notably so in the case of tonsillitis or lymphadenitis; moreover, these two infections are never initiated by tonsillectomy. It is important to eradicate the lower pole."

**THE ETIOLOGY AND TREATMENT OF MINER'S NYSTAGMUS, WITH A REVIEW OF 100 CASES.**—The author considers that the factors contributing to miner's nystagmus, arranged in the order of their relative frequency and importance, are as follows:

(1) **Inadequate Light:** Ninety-nine per cent. of the cases had been using the Lock lamp for a number of years. Only one case was found when the naked light was allowed, and here other causes were present. The Lock lamp must be nine feet from the farthest point of the mandril, so the workman is staring into comparative darkness. In certain parts of Scotland, where the naked light is used, miner's nystagmus is practically unknown.

(2) **Errors of Refraction:** Ninety per cent. had errors of refraction, while in three cases the irritation was so great that no examination could be made. Of the 90 per cent., 48 per cent. had astigmatism (myopic, hypermetropic or mixed); 27 per cent. had simple hypermetropic, and 15 per cent. simple myopia.



(3) Straining of the extrinsic muscles of the eyeball: This is the result of the two foregoing factors. In all cases the workman has his eyes fixed in a staring, strained position for long periods; either downwards and laterally, as in the narrow seams, or upwards, as in wide seams.

(4) Neurotic temperament: The inability on the part of a very large number of men with nystagmus to concentrate their physical or mental powers in any particular line of action guides us to the conclusion that such inability is probably much more the cause than the effect of the nystagmus.

Prevention resolves itself into medical examination of all men engaged to work under ground, and periodic examination of all underground workers for the presence of refractive errors, any sign of incipient nystagmus, and for physical or nervous debility. To this must be added the importance of adequate light. The curative treatment may be summed up in a single sentence: Rest, strychnia and the correction of refractive error.—*F. N. Browne and J. Ross Mackenzie. British Med. Jour.*

WILLIAM SPENCER, M. D.

SYMPATHETIC CHOROIDITIS.—The author describes a boy, aged nine years, who had been injured four days before he consulted the writer. In spite of treatment the inflammatory reaction was severe and resulted finally in a hypopyon. Gradually the inflammatory symptoms receded and the eye became somewhat softer. Two months later the patient was again seen, the fellow eye was affected, the writer believes, by a sympathetic inflammation. Four and a half months after the injury, and a little over two months after the onset of the sympathetic inflammation, the choroiditis developed. When first seen there were found seven spots, differing in size and appearance, but all uniformly round and sharp in outline. The larger ones had an ivory color. The smaller ones were more yellow, and the smallest ones had a bright golden, shining appearance. We have then, in this case, one of the few hitherto observed cases of characteristic sympathetic choroiditis without a previous cyclitis, and an iritis which was of the mildest type and which never interfered with an ophthalmoscopic examination in the least.—*Dr. Adolf Alt. Annals of Ophthalmology.*

WILLIAM SPENCER, M. D.

DISCUSSION ON SALVARSAN IN DISEASES OF THE EYE.—In opening the discussion Mr. Sydney Stephenson limited his remarks to the action of salvarsan in syphilitic diseases of the eye. The remedy, he thought, was best given in series, by the intravenous route, and he was of opinion that it should be supplemented by mercurial inunctions. He did not believe that it had any harmful effect upon the optic nerve, healthy or diseased. Its administration did not of necessity prevent the subsequent appearance of syphilitic diseases of the eye. In the treatment of interstitial keratitis due to inherited syphilis, good results might be obtained by a series of injections, but a single injection, in Mr. Stephenson's experience, seldom produced any marked effect. Salvarsan acted better and more speedily than mercury in the iridocyclitis of secondary syphilis. He considered

that the serum reaction should throughout remain the touchstone as to the efficacy of treatment and the permanence of cure.—*Sydney Stephenson. Brit. Med. Journal.*

WILLIAM SPENCER, M. D.

**MORGAGNIAN CATARACT.**—Morgagnian cataracts are not of common occurrence nowadays, owing perhaps to the practice of operation at the stage of maturity; and it may be said that the younger surgeons rarely ever see them. There are indeed but few references to them in the literature of the past ten years. Clinically such cataracts are usually monocular and long-standing. They may be of congenital origin, or secondary to uveal disease. They never remain after traumatism nor after operative procedures. The cortex liquifies so that the nucleus floats more or less freely in the fluid within the capsule, causing the visual acuity to vary from time to time. The nucleus may remain permanently below the pupillary space and the vision may become destroyed, and in some cases complete absorption ensues. Heberg strongly advises that cataracts should not be allowed to go on to hypermaturity, because of the dangers and complications likely to attend during the operation for their removal.—*Dr. Burton Chance. Annals of Ophthalmology.*

WILLIAM SPENCER, M. D.

**ECLAMPSIA.**—V. Olshausen, in a brief and clear cut article, summarizes this whole subject. After commenting upon the large number of recent articles on eclampsia, he says that many authors write as though this subject had been pretty thoroughly cleared up, whereas he believes that we are still quite in the dark. We do not yet know the character of the eclampsia poison and consequently we are in the dark concerning the treatment. Our treatment must be empirical, and is likely to remain so for some time to come. It is true we have made certain advances in treatment. Twenty-five years ago the usual mortality was 30 per cent. Probably 10 per cent. more recover now, but the fact remains that the serious cases do not recover, due to the fact that we have no rational therapie. The treatment approaches this in perhaps a single respect, in so far that early delivery in a certain number of cases is lifesaving. Since other remedies have failed, and narcotics also are ineffective, we must look farther. Venesection, not often used by the internist, should however be retained by the obstetrician because in eclampsia next to the early delivery, is the most effective remedy. One or two hundred cubic centimeters are not sufficient; rather four or five hundred cubic centimeters should be drawn. Venesection acts best in those cases where the convulsions do not cease after delivery or are then renewed or frequently recur. In such cases the promptest results are seen, and the author refers to four cases.—*ZEITSCHR f. G. w. G., Vol. 71-677.*

THEODORE J. GRAMM, M. D.

**THE SIGNIFICANCE OF NON-HAEMOLYTIC STREPTOCOCCI IN PUERPERAL INFECTION.**—The discovery that some forms of streptococci have the power of dissolving the coloring matter of red blood corpuscles and first

practically used in 1903 by Schottmuller for the purpose of differentiating various forms of streptococci has been the subject of much painstaking investigation ever since. Many investigators thought that in the possession of this power of hemolysis, possessed by some forms of streptococci, we were able to recognize those varieties which caused serious puerperal infection, so that hemolysis indicated pathogenicity. Without reviewing further the history and details of this very interesting subject which Trangott mentions in his article, it is however important to state that his studies have led him to conclude that the non-hemolytic streptococci and diplostreptococci as well as the hemolytic forms are able to cause all forms of puerperal infection, and he is of the opinion that we are not able to place the amount of reliance upon hemolysis which it was once thought to possess. Indeed he believes that this power has nothing to do with virulence and pathogenicity.—*Zeitschr. f. G. w. G.* Vol. 71-476.

THEODORE J. GRAMM, M. D.

ENDOGENOUS PUERPERAL INFECTION.—The occurrence of puerperal infection in spite of the strictest antiseptic precautions has attracted many investigators to this difficult and important problem. Thus Pankow has recently studied it and he concludes that we cannot deny the possibility of infection with endogenous micro-organisms. In primiparae we may count upon 5 per cent. of infections with endogenous germs even with uncomplicated labor. If the cases be examined per vaginam we may look for 4 per cent. more. In multiparae 3 per cent. are likely to be infected in this manner, and 2 per cent. if vaginal examination be performed. This higher percentage among primiparae is due to the more prolonged duration of labor, the greater likelihood of retained secretions, and the greater injuries to the genital canal. Spontaneous infection with endogenous germs may even have a fatal termination. Just how far operative delivery favors artificial infection with endogenous germs has not been statistically determined, but it is probably comparatively frequent in view of the greater injuries to tissues from the operative procedure. It is probably true that in well conducted institutions infection from exogenous germs rarely occurs at present. In private practice endogenous infection cannot be readily studied. But even in general practice it is no longer justifiable in every case to cast the blame upon the obstetrician, and the statement that "infection comes from without" can to-day only be interpreted for hospital cases as referring to the external genitalia, since the germs causing endogenous infection are not usually native there but proceed from the vulva. The healthy vagina has the power to destroy introduced pathogenic germs; but this power is lost intra partum when the discharging blood and amniotic fluid have changed its normal secretion. The theory of the self-cleansing powers of the vagina still holds good for it has been shown that while many colonies may be grown from the secretion taken from the vulva, they diminish in that from the introitus, while from that of the fundus of the vagina none can be grown. The recent omission of disinfecting the vagina and vulva has not materially increased the puerperal morbidity.—*Zeitschr. f. G. w. G.* Vol. 71-449.

THEODORE J. GRAMM, M. D.



## Monthly Retrospect

### OF HOMOEOPATHIC MATERIA MEDICA AND THERAPEUTICS

CONDUCTED BY DR. DONALD MacFARLAN  
PHILADELPHIA

**ECHINACEA.**—Two cases were verbally reported to us. A girl's arm swelled up enormously—it started with a "pimple." The old school attendant could do nothing and advised amputation which was refused. The other, a man, was apparently of a similar nature but in the leg; the old school—or new school—man advised amputation, which was refused by the patient. Both were cured by a homœopath, who gave them echinacea. There does not seem to be much in these cases, and yet had the advice of the scientific men (they were hospital men) been followed one citizen would have been minus an arm and one citizen a leg—if they had survived. Discouraging about micro-organisms with formidable names, antibodies, opsonins, and the rest, is very impressive, but it takes the homopathic simples to restore the patient to health quickly, safely and pleasantly. Why the world wants anything else is beyond the ken of reason.—*Practical Pointers Act Recorder.*

**DIPHTHERIA.**—As we are having several cases of diphtheria in Des Moines this is a good time to review the remedies which are useful in the treatment of patients suffering from this dreaded disease.

**Anti-toxine.**—Just a word, in passing, about anti-toxine. The question of the efficacy is still a mooted one. Although more physicians of both schools use it than ten years ago. More than that the public have been instructed to believe that it should be administered. For that reason I am in the habit of giving it if the patients or parents express a desire for having it used. At the same time I use what seems to me to be the indicated remedy.

**Belladonna.**—The only possible place belladonna can have in this disease is a prophylactic. Does it so act? I feel certain that it does, as certain as I am that any drug acts under any condition. Why? Because I have visited patients and obtained the following history of cases. Twenty-four or thirty-six hours prior the throat was bright red, the tissue swollen and dry, the entire mucous membrane of mouth and throat red and dry. Yet there was no thirst. There had been a marked chill, followed in a few hours by high fever. The urine had been profuse and watery at first. At the time of my visit the membrane had developed and most of the symptoms changed. A few days later I have been called to

brothers and sisters of these same patients presenting all the symptoms mentioned above except the membrane, have given belladonna and no membrane or other symptoms of diphtheria ever developed. So I have been convinced that in many cases belladonna has aborted the disease while in as many others it has lightened the severity of its symptoms. I use the 3d, 6th, 30th and 200th.

*Arsenicum Alb.*—Rapid and marked prostration; great restlessness; membrane dark and putrid; dark exudate on mucous membrane of mouth; black sordes on teeth; horribly offensive breath; dark bloody discharge from the nose; stools thin, dark and frequent; pulse rapid and weak; face pinched and anxious; urine scanty and albuminous; stomach so irritable it is difficult to nourish the patient, water especially distressing and provocative of emesis. Use 6th and 30th.

*Iodide of Mercury.*—Mouth excessively moist; tongue covered with a heavy, whitish yellow coating; tongue swollen showing the imprint of the teeth; breath foul; tonsils badly swollen and covered with a thick grayish membrane; the glands of the neck swollen and tender; pain in the back; aching generally of all the muscles; all symptoms worse at night and from cold air; body is covered with an oily perspiration; urine dark and scanty; patient is mentally sluggish but disgusted. Give the 3d and 6th every three hours.

*Apis*—Marked tumefaction both externally and internally; mentally drowsy and indifferent; urine dark, scanty and albuminous; a puffy, glassy, shiny appearance of the fauces at first, later a dirty grayish white membrane; the vulva is oedematous; no thirst; stinging and burning in the throat; dysphasia; difficult deglutition; some times marked dyspnoea; stools watery yellow and as a rule painless; pulse rapid, weak, irregular.

I have had several cases of post-diphtheretic paralysis follow diphtheria calling for apis. I use the 3d, 6th and 30th.

*Phytolacca.*—Tonsils swollen, dark red almost purple, fauces dry and sore; like lachesis; the above symptoms of phytolacca are aggravated by hot drinks; a puckered, choking sensation in throat; high temperature; a stiff, aching feeling in the back; urine dark and albuminous; stools hard; tongue very heavily coated; the membrane is not very extensive, nor usually necrotic and there is seldom if ever any hemorrhage. The patient's history generally reveals a tendency to rheumatism and glandular enlargement. Use the 3d.

*Ailanthus.*—Throat dusky red; incipient, ulcerative points which are soon covered by a grayish exudate; patient is drowsy, torpid, stupid; muttering delirium; skin dark red; ichorous discharges from nose. Use the 3d.

*Lachesis.*—Extreme sensitiveness, both externally and internally; any pressure from touch or bands causes a sense of suffocation; marked difficulty in swallowing, worse on attempting to swallow warm drinks; regurgitation of food through the nose; sensation of a lump in the throat when attempting to swallow; throat at first purple then covered by a thin membrane which begins on left side; bleeding follows detachment of membrane, frequently from the nose; a low muttering delirium; stools bloody, decomposed, offensive; urine dark and contains pus, albumen and speck resembling burnt straw; pulse rapid and weak.

*Nitric Acid.* A watery, offensive discharge from the nose which ex-coriates any part which it touches; patches of membrane in the nares at the corners of the mouth and in the buccal cavities; sticking, splinter like pains; fauces and glands badly swollen; high temperature; deglutition very difficult, causing cutting pains; frequent hemorrhages from beneath the patches of membrane; nausea and vomiting of tenacious bloody purulent mucus; in some cases ulceration of the rectum with dysenteric stools; urine of a strong offensive odor also contains albumen. The mental condition is one of irritability and peevishness, alternating with anxiety and despondency. Give 6th or 12th.—*Iowa Homœopathic Journal.*

BRIEF NOTES ON CALCAREA CARB. WITH VERIFICATIONS OF SOME OF ITS LESS WELL-KNOWN INDICATIONS.—By Guy Beckley Stearns, M. D.—It is not the purpose in these brief notes to give anything new about calcarea carb., as it is one of our best proven remedies, and probably nothing new could be written about it.

But in the hurry of a busy practice, unless one is constantly comparing his cases with the recorded provings and verifications in the materia medica, many important indications slip from his memory.

Everyone is familiar with the general picture of calcarea carb. and its inestimable value in the treatment of children. The fat, fair-haired, pot-bellied youngsters with sweaty heads; the sour-smelling babies with voracious appetites; the cross infants who crave eggs, and eat dirt and other indigestible things; are prone to diarrhœa and are apt to be in the best health when constipated; who have enlarged cervical glands which tend to break down, and suffer from suppurating middle ears; who are always taking cold and continually have the snuffles.

As familiar are the fair-haired and fair-skinned adults, who get out of breath on walking up the least incline, who have an excess of adipose tissue, who take cold on the least exposure, are always chilly, and are always miserable when the weather is cold and damp, though they stand the dry cold very well; who perspire much, have cold, clammy feet, cold abdomens, and in women whose menstrual periods come too early and are too profuse.

All of the above is so familiar as to be at everyone's finger tips, and verifications would be but repeating the experiences of everyone.

But this very familiarity with such prominent symptoms is prone to limit one's knowledge and use of a remedy.

The type of the calcarea patient as taught is so prominent that one would hesitate to give calcarea excepting in fair complexioned, obese patients, and yet some of its most brilliant cures have been made in just the opposite type.

My first experience in such a case was in a young college student, a trained athlete, who was on the college foot ball team. He was dark, almost swarthy, and would be picked out from a crowd to represent the nux vomica type. For a year or so he had overtrained and during the autumn previous to coming to me in February had suffered from diarrhœa. This was checked, after some heavy drugging, by blackberry brandy. He then became constipated and did not feel well for two or three months, and finally came down with the worst attack of jaundice I have ever seen.



His skin was a deep orange with a greenish tinge, and he was as crabbed and miserable as his skin was yellow. *Nux vomica* and *chelidonium* were given without benefit, when a careful review of the case was made. Going back over his case from the jaundice to the period of constipation and lassitude which followed the repressed diarrhoea was the history of physical over-training. He was a hard student as well as athlete, and both his brain and muscular system were overworked.

I consulted with Dr. Spencer Carleton and he called attention to the following in Hering's Cards under *calcarea carb.*: "Loss of appetite when over-worked (horses when over-driven)." For the benefit of those who do not know of these cards, they were published by Constantine Hering in the form of little slips, with a characteristic printed on one side and the drug to which it belongs on the other, and were for the purpose of studying and memorizing characteristics.

This particular characteristic, which is a verification of *calcarea* deduced from a knowledge of the general action of the drug, appears, so far as I know, in no other place.

It may seem a long jump from a case of jaundice to over-driven horses and the loss of appetite from over-work, but it was the key to the case and the remedy.

When one stops to consider, what could more vividly represent the case we have to deal with than a horse jaded by a long season of hard driving? *Calcarea carb.* was given in the 200th dilution, and I have never seen so prompt or perfect a response to any remedy in a similar condition. Since then I have many times had occasion to use this remedy for conditions of various kinds, where they could be traced to a jaded state due to over-work, whether physical or mental. This is especially true of chronic recurrent headaches in brain-workers where other symptoms agree. A strong indication is where the pain is relieved by pressing the head against some cold, hard substance, as the cold, plastered wall of a room. The pain is usually atrocious.

The mental symptoms of *calcarea* I have verified many times and the remedy has often been useful in insomnia.

As is well known, *calcarea* is both the chronic of and the complement to *belladonna*, and in some respects its mental symptoms are surprisingly similar. The difference is that *calcarea* will be given in cases which show the need of a remedy of more profound constitutional action than that of *belladonna*.

One of the uses I have found for it is in *delirium tremens*. Not in a simple drunk, but in the profound chronic alcoholic poisoning which carries the patient near death. The character of the delirium is active and full of fear, with hallucinations of rats, fire, etc. But the peculiarity is that these come when the patient closes the eyes, but disappear again when the eyes are opened. There is no sleep for these patients because they dare not close their eyes. Another indication in this condition is profuse perspiration, and great weakness and slow convalescence, with prominence of the veins on the extremities. The veins stand out large and blue. It is a venous rather than a capillary stasis.

These patients when given *calcarea* do not relapse into alcoholic excess as soon as when given the usual remedies for this condition.

In insomnia calcarea is similar to belladonna. The patient may be sleepy, but as soon as the eyes are closed everything comes vividly into the mind; thoughts, scenes, visions and even hallucinations.

In lung conditions calcarea is occasionally indicated upon its constitutional symptoms, especially when the middle of the right lung is affected and cavities have formed. In two cases of tuberculosis it was helpful; in one curative and in the other palliative; and in both there was a peculiar character to the sputum, which I have never observed in any other case, nor do I find it in the books, and I give it for what it is worth. The sputum looked exactly like white balls of cotton, which floated in loose, though undisseminated, lumps in the water of the sputum cups.

One was a hopeless case, with large cavities in the right lung, and she could not sleep because of the faces which appeared to her when she closed her eyes. Calcarea gave her perfect sleep, and relieved her of the restlessness and other distress of impending dissolution, as she died easily ten days later. The other was calcarea carb. in type and symptoms, and was apparently cured. Her case was not far advanced.

On the symptoms "appearance of the menses from any emotion" and "the occasional show of blood between the menstrual periods" I gave calcarea in a case of nasal polypus. The polypus disappeared, but her dysmenorrhœa, which was the worst I have ever seen, was not changed.

Hering mentions calcarea as being useful after sulphur where the pupils remain dilated. This I have verified a few times, once quite brilliantly in a case of Bright's disease with ascites. The patient had been benefited by sulphur, but her abdomen became so distended with fluid that paracentesis seemed necessary.

I observed that her pupils were widely dilated and gave calcarea carb., with the result that she began to pass large amounts of urine, and in a few days her abdomen was down to the normal size.

She died two and a half years later, but was not again troubled with ascites.

I have also observed the correctness of the old writers' dictum that sulphur should never be given after calcarea, although calcarea is frequently useful after sulphur. So if there is any doubt in a case as to which is indicated I always select sulphur for the first prescription.

The statement of Hering that calcarea should not be repeated in elderly people I have also found to be usually true, though it can be repeated in children.—*Homœopathic Recorder*.

PHOSPHORIC ACID IN NEURASTHENIA.—A chronic, general nervous debility, usually with burning pain in spine and with general apathy: weakness in morning after rising, with apathy: sour eructations after eating; a crushing, pressive headache in the vertex aggravated by mental exertion: aching as if the vertex had been beaten; the hair becomes grey early and falls out, the effect of mental strain: gums bleed easily; diarrhea, thin, whitish, grey, often involuntary stools after excitement; milky urine loaded with phosphates, sometimes containing sugar; scraping sensation in the periosteum of all the bones is often found in tubercular patients: seminal emissions frequent. Stomach symptoms ameliorated by warm food, every draught of air aggravates. The 30th has served me the best  
—*International Homœopathic Review*.

# THE HAHNEMANNIAN MONTHLY.

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JUNE, 1913

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**A REVISION OF THE CONCEPTS OF HOMŒOPATHY: DID HAHNEMANN  
CONSTRUCT THEM TOO HASTILY OR ERRONEOUSLY FROM  
THE DATA AT HIS COMMAND, OR ARE THEY  
SCIENTIFICALLY CORRECT?**

BY

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(Read before the Maryland State Homoeopathic Medical Society, May 7, 1913.)

To give the foregoing interrogation the consideration its grave importance demands involves a thorough examination into that great work, Hahnemann's Organon of Medicine. And not only this, but it is necessary to familiarize one's self with the state of therapeutics at the time the foundations of the system of homœopathy were laid. It is further necessary to realize the fact that Hahnemann's work was that of a great reformer, that there has been progress in all fields of knowledge since the concepts in question were constructed, that many things have been proven possible that a century ago were deemed impossible, that freedom of opinion has reached a point beyond the most sanguine expectation of Hahnemann, and that the medical world has been reformed, reconstructed in its mode of thought to the extent of transfiguration. Furthermore, it must be remembered that Hahnemann was in his day and generation one of the most liberal and progressive of men, and were he now living he would still hold the same relative position in the medical world. He condemned nothing without



reason and he taught nothing without reason; in fine, he was pre-eminently a man of reason. This, however, does not mean that he was infallible, that he was never mistaken. He was human, and "to err is human."

There are certain fundamental truths which time does not change, it matters not what new facts are discovered, and there are certain truths which owe their verity to certain contingencies, being true *if* this, that or the other qualification exists. Thus, it is a commonly accepted proposition that the same cause will always produce the same effect, but this is only conditionally true, the qualification being that the same conditions must always be present.

In the present instance, however, we are dealing with unalterable truths, as the result of our investigations should reveal. Either Hahnemann's idea of the full significance of homœopathy is true for all time, or it is untrue for all time. There is no qualification here. When the tenets of his faith were submitted to the world in perfected form, the data which stimulated their conception were sufficient for the purposes of this past master in philosophy. And if they are found imperfect in our day of wonderful knowledge, then, from the standpoint of the eternal verities, they were imperfect in the day of their birth. If homœopathy was true in the past, then it is just as true in the present; the correctness of its interpretation depending upon the limitations of the master, the philosopher.

Let us now consider in detail those postulates which may be regarded as fundamental concepts of Hahnemann's system of therapeutics, and in the following order:

1. Disease is deranged vitality.
2. The homœopathic treatment of disease.
3. The dynamic action of drugs.
4. Aggravation of conditions following homœopathic treatment.
5. The totality of symptoms of the patient.
6. The alternation of drugs.
7. The proving of drugs.
8. Local treatment of disease.

Hahnemann's views on the subject of chronic diseases, psora, sycosis, and olfaction of drugs, need not here be considered, as they bear no relation to the vital factors in this problem of homœopathy.

## DERANGED VITALITY.

First, then, let us consider the theory of equivalence of deranged vitality and disease.

The postulate that disease is due to deranged vitality and not to disturbance of the material organism, is laid down by Hahnemann as fundamental. This is a gratuitous assumption, as there is no way of proving the contention. We do know, however, that the various organs and tissues of the body manifest a variety of detectable physical changes, whether those changes be due to what are called natural diseases, accident, or drug effect, and we also know that such changes are many times amenable to the influence of drugs that are capable of producing similar physical conditions in the healthy organism. It is somewhat difficult to conceive of vital force becoming diseased. Vital force seems to be a *state* or *condition* rather than a *thing*. Through the various organs and tissues of the body this state or condition is manifested, and the character of the manifestation depends upon the degree of perfection or tissue through which this vital force acts, or in which the vital condition is demonstrated. When a steam engine is broken we do not regard the steam as being defective or in any way deranged, but we regard some part of the engine as inoperative. The steam may be in too great or too small an amount, but it does not become deranged in any manner; so we believe it is with the vital force which animates the human organism.

We therefore regard the hypothesis of deranged vitality as a basis for a system of pathology, as untenable, and consequently as an erroneously constructed concept.

## SIMILIA SIMILIBUS CURANTUR.

Second. The greatest of Hahnemann's great thoughts is embodied in the one word "homœopathy," a full and elaborate explanation of which is embraced in forty-one sections of his Organon. It is fair to assume that we are all sufficiently familiar with the meaning of homœopathy to render an explanation here unnecessary, and we will at once proceed to consider the reliability of this concept.

Is it a fact that similars are cured by similars? (We will not split hairs by discussing modes and tenses, but will let the

question stand as submitted.) Did Hippocrates, Aesclepiades, and Paracelsus really have glimmerings of a great therapeutic law through the befogging ignorance of their respective times? And did Hahnemann really bring together the factors necessary to the formation of a correct system of healing? Or were these men all mistaken?

That they were not mistaken is demonstrated in the fact many times substantiated, that a drug that will produce a definite condition in an approximately healthy human being will remove a similar state of affairs when found in ill health. Illustrations exist in the resemblance between belladonna pathogenetic effects and scarlatina, tuberculin effects and tuberculosis, hydrophobin effects and hydrophobia, ipecacuanha effects and pathological nausea, cantharis pathogenesis and dysuria, vaccinia and variola, etc., etc., etc. In fact, on this point, all who have put the theory to clinical test, agree; others should not be recognized in the discussion.

Homœopathy may be considered the keystone of the arch of Hahnemann's philosophy. While much has been done to belittle the work of this great man, and while many of his views have been placed in a position to make the most conservative of his followers doubt their kinship to the verities, yet no effort has ever succeeded in placing homœopathy outside the pale of science. A law of similars always has existed, exists now and always will exist. Whether it is always correctly interpreted by its adherents is quite another matter.

It is proper to state here that while homœopathy is the central fact in Hahnemann's philosophy, yet he neither discovered nor conceived it, but simply more fully demonstrated its existence than had ever been done before, and through this demonstration rendered the principle of practical utility. As a fundamental concept we are convinced that *similia similibus curantur* is correct.

#### THE DYNAMIC ACTION OF DRUGS.

Third. The next concept is that which assumes that drugs have an independent dynamic. As Hahnemann phrases this idea in Section 16 of his *Organon*: ". . . neither can such morbid disturbances, or in other words, such diseases, be removed by the physician, except in like manner, by means of the spiritual (dynamic virtual) countervailing agency of the suitable medicines acting upon the same vital principle, . . .



so that curative medicines possess the faculty of restoring, and do actually restore health, with concomitant functional harmony, by dynamic influence only, . . . ."

This is a pure assumption which can not be sustained by facts. It is true, that years before, that remarkable man, Paracelsus, taught much the same idea when he phrased this Hahnemannian drug "dynamic" as the "indwelling spirit" of the drug, but Paracelsus could offer no more proof of his hypothesis than could Hahnemann of his.

In Section 10 of his *Organon*, Hahnemann gives us food for thought bearing upon this dynamic point. He says: "The material organism deprived of its vital principle, is incapable of sensation, action, or self-preservation; it is the immaterial vital principle only, animating the former in its healthy and morbid condition, that imparts to it all sensation and enables it to perform all its functions."

The human organism, therefore, becomes inert, without power of action or reaction, when it is deprived of its vital principle. In other words, it is dead, although it may be physically constituted of a large number of individual elements, including a variety of salts—*natrum muriaticum* among them. But, according to Hahnemann, it would seem that though the vital principle of the body has departed, yet the vital principle of the various mineral salts incorporated in this body, has not departed, and that if from this inert, dead mass, without vital principle, carbonate of lime, phosphate of potash, *natrum muriaticum* or any other contained salt, be extracted it will be found by introducing it into a living body to have a definite *living* dynamic, which will bring about changes in this living human body. If the salts mentioned have an inherent vital principle capable of producing such positive pathogenetic and therapeutic changes as experience teaches, why is there no evidence of this drug dynamic other than that produced by its introduction into an organism which is animated by a vital principle? Why is it necessary that this drug dynamic should always need a living principle in the thing into which it is introduced to demonstrate the dynamic of the drug?

Such being the state of the case we hold to the belief that the drug has no vital principle, but that the manifestations which follow its administration to either the prover or the patient, are due to the attitude assumed by the human organism in its effort to do something in relation to that drug.

Because no evidence has been submitted which may be regarded as proof, we must conclude that the theory of the "dynamic action of drugs" has not been sustained, and that Hahnemann constructed this concept of his great philosophy upon insufficient data.

#### HOMOEOPATHIC AGGRAVATIONS.

Fourth. Concerning this idea Hahnemann expresses his view in Sections 157 to 161 inclusive of his classic, the subject title preceding these sections being as follows: "The medicinal disease, closely resembling, but rather more intense than the primitive one, called also homœopathic aggravation."

Briefly, the concept is, that when a drug is given to a patient in an unnecessarily large dose, or too frequently repeated though in proper dose, an aggravation of the condition will occur. From this it logically follows that no more of the drug should be given than is sufficient to bring about curative results. As all people are not equally sensitive to influences, drug influences among them, all people are not equally sensitive to drug aggravation; but as it is not possible to distinguish the difference in degree of sensibility of different persons, it is wise to give drugs in doses sufficiently large to bring about curative results in the average patient, until we discover that the given patient is not an average individual, but a hyper-sensitive, then we must be guided by circumstances in our conduct of the case.

Another view is, that all people are subject to drug aggravation when the perfectly homœopathically indicated drug is prescribed: the reason why so few apparent aggravations occur being that the perfect homœopathic prescription is rarely made. However, it matters not which view is correct, the fact is that aggravations do sometimes follow the administration of a drug which is reasonably homœopathic to the condition of the patient, and it is also a fact that the larger the amount of the drug prescribed the more certain is this aggravation to occur. We are therefore compelled to accept this idea of drug aggravation as one of the correct conclusions of Hahnemann.

#### TOTALITY OF SYMPTOMS.

Fifth. Another of Hahnemann's essential beliefs relates to

what is called the totality of symptoms of the patient to be cured. Theoretically, for the complete fulfilment of the law of similars it is necessary that the physician be able to "cover the totality" of the patient's symptoms with the totality of the pathogenetic drug symptoms. That this is not generally practicable, not to say impossible in the present state of our knowledge, it is only necessary to call attention to the fact that the physician must know not only all the detailed objective and subjective symptomatology of the patient to be treated, but he must know just as intimately and minutely all the similar symptomatic details which the indicated drug is capable of producing in a healthy prover. Unless he is in *a priori* possession of exactly such definite knowledge he can not scientifically cover this "totality" about which so much cant has been written.

That the great master, Hahnemann, "covered the totality" in all his patients, conservatively speaking, facts lead us to doubt. Indeed, when we consider the comparatively little that was known of pathology in his day, (at least of much of the finer pathological semieology with which the average diagnostician of to-day is familiar), we are reasonably sure that the number of cases in which Hahnemann deliberately and intelligently covered the patient's totality of symptoms with the totality of symptoms of the drug selected, were very limited. Hahnemann made wonderful cures, and as wonderful predictions of the similima for some of the most terrible of European epidemics, yet these cures and these *pre*-visional predictions did not rest upon *a priori* knowledge of the various symptomatic *totalities* concerned. They were to a greater or less extent generalizations, based upon a knowledge of a law which the master called the law of similars, and the cures resulted because of the fact that the resemblances between the symptomatology of the patient and the pathogenetic symptomatology of the drug existed in varying degrees, and yet cures resulted from the application of the similimum.

From a purely theoretical, or rather hypothetical, standpoint, the idea of the necessity for the fulfilment of a totality of symptoms in the practice of homœopathy, is not only correct, but it is essential to perfected homœopathy; but from a practical, working standpoint we may justly conclude that this concept of Hahnemann's therapeutic system was constructed without regard to the data at the command of the builder.



The practitioner of homœopathy should always *strive* to discover this double "totality," (it can do him no possible harm, on the contrary, it will make him a more accurate prescriber), but he must not be disappointed if he is not successful in reaching his goal. As has been said by the old *materia medica* teacher, Dr. W. J. Hawkes, "When one is familiar with three or four *characteristic* symptoms of each remedy, he has a good working basis for an accurate prescription."

#### THE ALTERNATION OF DRUGS.

Sixth. Another generalization which has been submitted by Hahnemann is, that but one drug should be prescribed at a time for the given condition. This idea is phrased as follows in Section 272 of the *Organon*: "In no instance is it requisite to employ more than one simple medicinal substance at a time."

There are, however, two exceptions to this general rule, one of which is that should two drugs be given to a prover for the purpose of discovering what results may follow, and the pathogenetic symptoms of these combined drugs be found to resemble some disease condition, these two drugs may be legitimately prescribed, because of the fact that in their combined condition they may be regarded as one agent, just as we may regard the twenty-odd ingredients which constitute the drug opium as one drug. Combinations may be extended to embrace quite a number of drugs, providing the combination is prescribed according to the indications suggested by the resemblance between the symptoms of the patient and the pathogenesis of the combination. This is the only way in which a combination of two or more drugs may be considered as even possibly homœopathic to a pathological condition.

Another exception to this rule is one to which Hahnemann has called attention. In a foot note to Section 40 of his *Organon*, when referring to the existence of a psoric and a venereal condition at the same time in the same organism, he says: "The cures which I have performed of these kinds of complicated diseases, together with the accurate experiments which I have made, have convinced me that they do not arise from an amalgamation of two diseases; but that the latter exist *separately* in the organism, each occupying the parts that are most in harmony with it. In short, the cure is effected in a very complete manner by administering alternately, and at the pro-

per time, mercurials, and antipsorics, each according to its appropriate dose and preparation."

Here we have testimony from the master himself that he does under certain circumstances find the alternation of drugs advisable; the condition being when two separate derangements exist in the same organism at the same time.

Excepting the modifications to which attention has been called, we are compelled to frankly accept this concept also as correctly constructed, in accordance with the requirements of Hahnemann's philosophy of therapeutics.

#### THE PROVING OF DRUGS.

Seventh. While the testing of drugs upon the healthy is usually conceded to belong characteristically to Hahnemann's system, yet, as we know, this idea was a suggestion of the renowned Haller, which Hahnemann adopted as essential to the practice of homœopathy.

Disease is a deviation from the line of health of the individual, and the purpose of correcting this deviation and restoring the patient to health is the work of the physician. To do this it is necessary to adopt some means upon which dependence may be placed for satisfactory results. Hahnemann's experimental tests with well-known drugs upon the healthy, suggested that these drugs would produce conditions and symptoms in the experimenters strongly resembling certain conditions which it was known these tested drugs would cure. Following these early experiments—beginning with cinchona—many others were made with a large number of drugs, and upon clinical test the same relationship between the experimental drug symptoms and those of the patients treated, was found to exist. Thus was fully established the homœopathic relationship between drug disease and sickness. In no other way could this relationship have been definitely proved; in no other way could the clear and satisfactory demonstration of the law have been made.

Resulting from this character of work a perfectly legitimate outgrowth has developed, that of inferential homœopathy. This means that if a given drug has been known to produce in the healthy some definite gross effects—objective pathological changes, possibly—and when given to the sick has not only removed the gross condition similar to that found in its patho-

genesys, but has also caused the finer detailed morbid symptomatology to disappear, that drug is proven to be not only the agent homœopathic to the gross objective condition, but it is also inferentially homœopathic to the detailed symptomatology which may not have been observed among the effects of the drug upon the healthy organism.

So far as known there is no other way than the proving of drugs upon the approximately healthy, by which reliable information may be obtained upon which to base homœopathic prescriptions. The modern use of sera and nosodes generally does not modify this statement in the slightest, because, in the case of the sera it is well known that they are vital with power to produce the disease from which they are derived, if given in sufficient quantity, and consequently what is stated of proven drugs may equally be stated of them.

From the foregoing we feel safe in concluding that this concept is well grounded and scientifically correct.

#### LOCAL TREATMENT OF DISEASE.

Eighth. On the subject of local treatment in localized conditions Hahnemann held positive views. In his strictures upon such treatment he sensibly excepts surgical difficulties. He also equally as sensibly, in Section 203 of his inimitable classic, condemns the *exclusive* treatment by local means of local conditions which are simply circumscribed manifestations of some general malady. He says: "Such, for example, as that of destroying a psoric eruption on the skin by means of ointments, healing up a chancre by the use of caustic, destroying the granulations of syphilis by ligature, excision, or the application of a hot iron—is not only useless but injurious."

Thus far we unite with Hahnemann in his attitude towards topical applications, but we hesitate to follow the view he voices in Section 197. Herein he thus expresses himself: "The simultaneous application of a remedy internally and externally, in a disease whose principal symptom is a permanent local evil, brings one serious disadvantage with it—the external affection usually disappears faster than the internal malady, which gives rise to an erroneous impression that the cure is complete, or at least it becomes difficult, and sometimes impossible, to judge whether the entire disease has been destroyed or not by the internal remedy."



The view of the case expressed in this section is not consistent with Hahnemann's hypothesis that disease is a derangement of the *dynamis* of the organism. If it be the *dynamis* and not the material organism that becomes diseased, then it is somewhat difficult to understand what difference it makes whether or not the remedy be applied to the part manifesting the local disturbance or to any other avenue of approach to this *dynamis*.

There can be no harm done in the application of mild ointments to ulcers and other local conditions, antiphlogistine to rheumatic joints, ice to a congested brain, or belladonna stupes to the abdomen in peritonitis—whether puerperal, diffused or localized about the appendix. By the use of such adjuvants the internal treatment is greatly aided, and not retarded; and in their use we run no risk of creating an erroneous impression that the cure is complete when the localized disturbance subsides. In some cases the cure *is* complete when the local disturbance subsides. In illustration, itch may be cited, but on referring to page 33 of Hering's 1848 edition of the *Organon*, we find Hahnemann clearly stating his disapproval of the local treatment of this malady. He here condemns the use of sulphur ointment, because, in his opinion, it will "drive back the itch from the skin." In this statement we find that Hahnemann did not understand the nature of scabies. No doubt there are states of the organism which favor the entertainment of the unbidden itch guest, but the local application of sulphur ointment has killed this miserable parasite with nothing but benefit to the general health of the patient, too often to justify the practical healer of the sick in wasting time in search for the *similimum*.

It is, however, possible to use applications that will suppress local manifestations, and of course these should be avoided; as, for example, when astringent agents, whether drugs or cold in the form of ice or cold water, are applied in local congestions which may have some internal origin. In such cases metastasis may be caused to some vital organ, thus producing disastrous results. But this question of suppression by many of the mild local applications has been used as a bugaboo to scare people who do too little thinking to honor the brains they have. I think we may go a step further than the foregoing remarks may suggest, and confess to a belief that even in cases where a local condition has been positively and definitely suppressed, it is possible that the recuperative force of the organ-

ism may be strong enough to repel the effects of the suppression, and by this definite protective attitude cause the organism to return to a normal condition. This belief may be entertained, without at the same time considering local suppression wise under the circumstances stated, of course.

Hahnemann did not give this recuperative strength of the organism credit for sufficient health-restoring power. He believed the *dynamis* which he imagined to reside in drugs to be the cause of cures. His tendency was to depend too entirely upon this *dynamis*, and not enough upon the dynamis of the organism.

Our general conclusion as to the correctness of this Hahnemannian concept, therefore, is, that local applications need not necessarily complicate the case under treatment; that they need not suppress the local manifestations of a general condition; but that, on the whole, judiciously selected applications may be unqualifiedly beneficial, and thus assist the vitality of the patient in the curative direction suggested by the drug which has been prescribed in accordance with the strictest homœopathic indications. The condemnation of the use of local applications, therefore, is not necessary to the practice of homœopathy, and, as a concept formulated upon such a basis, is erroneous.

You have now had submitted to you the fundamental necessities of perfected homœopathy, and the requirements for its practical application, and in the analysis we have discovered that some of Hahnemann's concepts are strictly in accordance with modern scientific developments, while others can not be substantiated as demonstrable. Briefly, therefore, the result is as follows:

First. The hypothesis of deranged vitality as the basis of pathology, is erroneous.

Second. The homœopathic theory is correctly formulated.

Third. There is no proof of the dynamic action of drugs, as stated by Hahnemann, because of the fact that the existence of an individual vitality in each drug, an "indwelling spirit," can not be proved.

Fourth. The theory of drug aggravation is correct.

Fifth. For the complete fulfilment of the requirements of homœopathy, the concept of the totality of symptoms is correct, but it is impracticable.

Sixth. For the consistent practice of homœopathy the fol-

lowing concept is in accordance with scientific requirements: "In no instance is it requisite to employ more than *one simple* medicinal substance at a time."

Seventh. The testing of drugs upon the approximately healthy human being is a fundamental necessity of homœopathy.

Eighth. The unqualified condemnation of the local treatment of disease manifestations is unwise, and the exclusion of means of this kind from the resources of the homœopathic practitioner is without the justification of the homœopathic law; this proscription, therefore, has been too hastily promulgated.

From the foregoing we find laid bare the solid foundation upon which Hahnemann's philosophy stands, and up to the present time nothing has been advanced to disprove the truth of the following fundamental concepts:

The law of similars has been many times demonstrated to be true; when drugs are prescribed in strict accordance with this law an initial aggravation of the patient's condition *may* occur; for the complete fulfilment of homœopathy it is necessary to know both the totality of the drug symptomatology and the totality of the symptoms of the patient, and to base the prescription upon the perfect resemblance between the two totalities; one single remedy should be prescribed at a time; and for the purpose of securing information leading to the practical use of drugs in disease, it is necessary that they be tested upon the healthy human being.

Such, our analysis suggests, is fundamentally necessary for a belief in homœopathy and the practical application of the system to the daily needs of the sick.

The exclusive application of this therapeutic system to the sick by the busy modern practitioner of medicine, is far more difficult than it is for the physician of leisure whose practice is limited to his office or to a few daily calls. The former is of necessity driven to hunt for short cuts, while the latter has much more time at his disposal in which to give attention to each individual case. One of the short cuts is that suggested by Dr. Hawkes, which permits the substitution of three or four "characteristics" for the "totality."

It is folly in our day to say that there is no other way than the homœopathic by which cures may be made, and that all other therapeutic agencies are either ineffective or harmful. Whatever may have been true in Hahnemann's time, it is not



true now. When Hahnemann instituted his great reform, conditions were very different. In fact it is safe to say that had Hahnemann lived in 1913 instead of 1813 he would not have written his *Organon* in its present form. No doubt he would have written as ardently of the effectiveness of the law of similars, but he would not have so severely condemned everything that was not homœopathic. In the days of Hahnemann there did not exist many procedures which are now in daily use by the active practitioner, and which, although bearing no relation to homœopathy, do not interfere with the ultimate cure of the patient by the law of similars: e. g., oxidizing and sterilizing gargles in sore throats, anodynes and analgesics in acute localized pain, local antispasmodics in asthma, digestive ferments in acute indigestion, rational purgatives in obstinate constipation, etc., etc. And further, there are times when the modern practitioner finds it to the advantage of his patient, and of himself also, to resort to means that are non-homœopathic even for the *ultimate* cure of his patient; e. g., various forms of electricity, massage, mechano-therapy generally, special diet, and in acute cases drugs that simply palliate or act allopathically.

Being both philosophical and scientific, Hahnemann, were he now living, would doubtless recognize the good in many of the procedures of our day which are not homœopathic, and have put the stamp of his approval upon them.

Practicing medicine to heal the sick, and practicing medicine to prove a theory, are two different things, and the successful practitioner of to-day is he who heals the sick.

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THE EFFECT OF SILICON COMPOUNDS ON LEUCOCYTOSIS.—After having been regarded generally (outside homœopathic circles) as inert, the silicon compounds have begun to attract attention as remedies. Paracelsus and Glauber both used them (chiefly for gout and stone), and in our own day Professor Schulz has not only used silicea, but "proved" it. Several other German medical men have worked at the silicea problem, Siegfried, Kobert, Zickgraf and Schwarz. The last named has experimented with the mineral water of the Glashager Spring which contains about one in 25,000 parts of silicea. Twenty-three persons took the mineral water in varying quantities. Three showed no result. All the rest showed a leucocytosis which varied from an increase of 40 per cent. to 216 per cent. This effect of silicea may account in large degree for the value of the remedy in homœopathic hands for old suppurations, fistulæ, etc. It is a very noteworthy experiment that we record here.—*The Homœopathic World*.

**THOUGHTS ON GENERAL CHRONIC DISEASES.**

BY

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CHRONIC diseases form a class of diseases well suited for office treatment, hence this class of disease is a good specialty for those who wish to do office practice exclusively. Chronic diseases have been very much overlooked by the average physician except from a surgical standpoint and this is the way the osteopath, chiropractor, mechano-therapist, physical culturist and the various other forms of "drugless healers" have flourished.

The various forms of "drugless healers" specialize in chronic diseases and do office practice almost exclusively as they are all illegal practitioners except the osteopath, in a few states, and have no ethics, they do not hesitate to advertise boldly as to their ability and even guarantee cures in sometimes incurable cases without medicine or surgery. They often do an extensive practice especially for a certain class of thinkers. Osteopathy, chiropractic, etc., is nothing but massage and Swedish movement. These new names for an old and very old method of treatment catch many people. They think they are getting something new when they are getting something as old as any form of treatment on record. Massage has almost been discarded by the medical profession for a long time, as its use as a therapeutic agent is very limited. A physician with a good vibrator can do all and much more than can be done by massage with the hands.

Massage with the hands can be compared to the vibrator in about the same comparison that an old truck ox-cart can be compared to an automobile.

There is more or less psychic influence between the patient and the one treating him. If it was not for this hypnotic influence these various forms of "drugless healers" would soon have to quit practice, for this influence is the main thing in the treatment, as the massage, the treatments, adjustments, etc., that are used amount to practically nothing. The thinking public should be educated on this matter. Of course there is a class that do not think and a class that wants to be and must be "humbugged," and with this very class the "drugless healer"

will do business. The public should know that a person half educated in any subject or profession should not be trusted. The "drugless schools" give correspondence courses. The public should be informed that a reputable physician is one informed on all methods of healing and all branches of the healing art such as medicine, surgery, massage and all branches of drugless healing. We will often hear some one say that a chiropractor did so and so after a certain doctor had failed, etc., and produce such as evidence against the physician. In such instances it was about time for a change, or the chiropractor had a greater psychic influence or may have understood that particular condition better than the physician in attendance.

In medicine we believe in specialties or specialty practice.

If a person wishes to practice on any special line of diseases he should first take a regular medical college course and then he would be in shape to study some specialty.

If he wanted to be a specialist in massage or what is called chiropractic, he could do so intelligently, legally and ethically. No matter what specialty, a person selects, he should first get a complete legitimate education. In the medical profession it is a certain fact that a foundation must be laid upon which to build a general or a special practice.

How can a valvular lesion of the heart be diagnosed when one does not know the anatomy of the heart?

In a medical college the first two years of nine months each is devoted to anatomy, physiology, chemistry and other fundamental branches. The chiropractor claims to understand these branches, but he learns them and all the rest he gets in from four to six weeks' correspondence course in many schools. A few of the chiropractic schools claim to put in four or more months. But they have no council to investigate, to see if even this is done and they do not take oath nor produce positive evidence as to how much time a student attends, as is the case in reputable medical colleges. The road to chiropractic practice (or adjustment as they call it in order to further the law) is an easy one and it is no wonder that almost every village is full of them. The course is short, no boards to pass, no license to be revoked, nor any conduct nor ethics to put them in bad standing in the profession.

If the student does not want to leave home to study chiropractic or most of the "drugless" forms of treatment, he can



take a correspondence course. Most schools that give a correspondence course specify very forcibly in their catalogues that the diplomas of correspondence course read as though it was a personal course.

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## THE TREATMENT OF GONORRHEAL ARTHRITIS.

BY

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It is certainly not with pride that I review the results in some of my old cases of gonorrheal arthritis, or gonorrheal rheumatism, as we were wont to call it some years ago.

I recall one case of an absolute ankylosis of the knee joint, one of absolute ankylosis of the elbow, one of great limitation of motion of the ankle, one of partial ankylosis of the wrist with inability to completely flex the fingers, owing to involvement of the tendon sheaths as well as the joint, and one severe chronic case that has limitation of motion of several of the joints due to metastasis of a chronic gonorrheal seminal vesiculitis.

Medical literature up until a year or so ago contained little on the treatment of gonorrheal arthritis that promised a restoration to the normal function,—I have reference to severe cases. The best result usually obtained was a partial disability caused by limitation of motion or else an ankylosis in a good position. It is now conceded that all joint inflammations are the result of infectious micro-organisms or their toxins, whether caused by gonococcus, streptococcus, bacillus coli communis, streptococcus rheumaticus, or other pathogenic bacteria. There is no idiopathic arthritis.

The result of a Neisserian infection of a joint depends upon the virulence of the infecting organism and the management of the joint lesion. Knowing the end result in the severe cases of gonorrheal arthritis, I was not surprised to find that most all of the cases in Dr. John B. Murphy's clinic applying for arthropasty were those of complete or nearly complete ankylosis which was brought about by gonorrheal metastasis. These metastases occur with a regularity as a secondary infection. Each type of infecting micro-organism has a definite period of

quiescence before the joint symptoms present themselves. The streptococcus infection of a joint comes on quickly, usually within twenty-four to forty-eight hours and is accompanied by a chill and high fever. With other micro-organisms than the streptococcus ten, twenty or thirty days elapse before the joint symptoms develop. The period usually allotted to grip and the staphylococcus is about nine days, pneumonia eleven to fifteen days, typhoid two to four weeks. The usual time for development of gonorrheal arthritis is from the eighteenth to the twenty-second day. The attack is sometimes precipitated earlier than this or it may take a much longer period as in cases of chronic gonorrhea with a vesiculitis or prostatitis. This gonorrheal metastasis usually starts as a multiple arthritis but as a rule after a couple of days all but one joint has cleared up and here this destructive process spends its fury.

There is little danger in confusing gonorrheal arthritis with a tubercular one. The Neisserian infection comes on suddenly, the symptoms are acute, pain is very severe; while the tuberculosis comes on slowly and gradually and never under three weeks after an injury. The tuberculin test is another aid to diagnosis.

The most frequent seat of gonorrheal arthritis is in the knee joint,—the ankle, wrist, elbow, shoulder, hip, temporo-maxillary, small joints of feet and hands and spinal articulations, following in the order named.

The capsule of the knee joint is able to withstand a great internal pressure. It is a regular leather bottle. One experimenter found that the capsule of the knee held from 70 to 120 pounds to the square inch and did not rupture.

An infected joint is destroyed primarily through the accumulation and pressure of the products of infection held under tension, as well as by the virulence of the infecting micro-organism. The synovial membrane of the articular surface of a joint is lined with a velvety layer of endothelial cells. During an infectious arthritis they are inflamed and pressed together by muscular contraction—nature's effort to immobilize, and are soon destroyed. Then a synechia occurs, which may eventually lead on to a bony ankylosis. The recognition of these important facts is the key note to successful treatment of gonorrheal arthritis.

Aspiration of the joint and drawing off considerable exudate lessens the tension. At the same time injecting from 5 to

10 c.c. of two per cent. formalin glycerin, which neutralizes the fluid in the joint cavity and also makes a bad culture medium for all micro-organisms; it likewise increases the polynuclear leucocytes to fight the invading bacteria. You may aspirate and inject every day or every second day or once a week, according to necessity. Ofttimes one or two injections are sufficient.

The inflamed articular surfaces of the joint must be separated and this is best done by extension, preferably Buck's adhesive dressing. This will greatly lessen the pain if the weight applied is sufficient to overcome muscular contraction. Murphy says to apply five pounds to the leg is like putting on a postage stamp. The weight must be sufficient, even if 25 pounds is required. Sometimes the inflammatory exudate is so thick it cannot be aspirated. Flakes and fibrin are deposited in the joint. In these cases it is best to incise the joint and wash out all inflammatory products with a sterile salt solution. Taking the knee as an example an incision should be made on either side of the patella; with the knee in a flexed position the joint cavity is more accessible. It can then be thoroughly cleaned out and immediately closed up again. There is no danger of an ankylosis from opening a joint if you keep out the drain, but you may have a permanent impairment of function if the joint is kept open. The endothelial cells are destroyed if exposed to the air any length of time.

In addition to these local surgical measures I consider the giving of the vaccines the next most important thing. The Neisser bacteria mixed is the most efficient. Starting with fifty million gonococci and increasing the dose to perhaps four hundred or five hundred million, if necessary, and the proportional dosage of the other accompanying bacteria.

I have never used phylacogens and do not know their value in these acute cases. The reports would lead me to believe that gonorrheal phylacogen is of more value in chronic cases. Some four or five years ago I used considerable antigonococcic serum made by P. D. & Co., and I never saw any appreciable effect. As soon as the acute symptoms have subsided, passive motion should be instituted. High frequency currents, electric light baths, baking, hydropathy, and the like, increase circulation to the part and promote absorption.

The Bier treatment of passive hyperaemia is of value in the sub-acute stage.



In all cases, but especially the more chronic ones, the deep urethra, seminal vesicles and prostate should be given appropriate treatment.

The salicylates, colchicine and other like remedies are of little value in these cases.

Among the homœopathic remedies guaiacum is of the most value.

To summarize the treatment:

First. The gonorrhœal vaccines (mixed).

Second. Aspirate, relieve tension and inject formalin and glycerin.

Third. Apply extension.

Fourth. If the case is not progressing favorably, incise and wash out joint cavity. Immediately close.

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### FLIES AS CARRIERS OF INFECTION.

BY

S. R. KLEIN, M. D., PH. D., M. A., NEW YORK.

THERE is no doubt any more that enteric fever can be conveyed by flies, and Austen observes that many cases of intestinal myosis is due to the larvae of the flies belonging to the genus *homolomyia* (*H. canicularis* Linn. and *Scarlasis* fabr.). They are probably to be traced to the parent flies having ova deposited on the anus when the patient has been using some country privy where these flies are common.

Austen thinks that *homolomyia canicularis* is very often mistaken for *musca domestica*, the true house fly; but it is smaller, narrower, and the fourth vein runs straight to the tip of the wing instead of being bent up at an angle as in *musca*. It is often called a young house fly by those who do not know that the larval stage is the period of growth in insects and that no insects grow, in the true sense of the word, after attaining the perfect state.

Now, that the summer season is coming, it is a very good idea to pay a little attention to this subject, for the only reason that mosquitos, flies and insects are in so many (1,000) cases the causes of terrible infections and horrible deaths.

I could mention innumerable cases where almost instant death occurred after the human being was bitten or infected by flies and insects.

Our late Professor of Surgery, Dr. Kovaes, of Budapest, died forty-eight hours after such a vehement attack. It occurred in 1905 near Budapest, when one hundred or more students of the Commercial High School took an excursion to the "Buda Eorsi Mountains," where they met on a lonely spot near where the Budai Keseru, viz., Hunyadi "Bitter Water" comes from, millions of peculiar flies which were unknown to them and their accompanying professor. The result was that thirty or forty of the students (I cannot remember the exact number) met their death a few days later. Some of them died of acute enteritis, a few contracted typhoid fever,

A very excellent paper on house flies is that by Dr. Howard, United States Department of Agriculture. He deals with all the flies which invade houses in the United States, mentioning *musca domestica*, *Stomoxys calcitrans*, *Pollenia rudis* (the cluster fly), *Musca stabulans*, a stable fly exactly like the common house fly and three species of so-called blue bottle fly, namely, *Calliphora erythrocephala*, the blond house fly, the small blue bottle fly, *Phormia terrae novae* and the green *Lucilia* *Cæsar*.

*Homolomyia canicularis* and *homolomyia brevis* also receive attention as does the small, jet black window fly, *Scenopygus fenestralis*, which breeds in the dust under carpets. The small and slender *sepsis violacea* often seen on window panes is also mentioned. Some more proof of flies as carriers of infection is furnished by the work of R. M. Buchanan, *Lancet*, p. 216, Vol. II, with *M. domestica* and the blue bottle fly, *M. vomitoria*. He describes the form and structure of the fly's torsus and shows how well adapted it is for carrying a large amount of infective material. He had positive results as regards transference of specific germs and growth on media, with swine fever, staphylococcal abscesses, pulmonary tuberculosis and anthrax. The conveyance of infection in the case of enteric fever was also successfully accomplished. The culture medium employed being that of MacConkey as modified by Grunbaum and Thume.

Major F. Smith draws attention to an important matter in regard to the breeding of the *musca entaeniata* and *anthomyia tonitru* in scattered deposits of human faeces and the occurrence of maggots of these flies in the soil under the faecal masses. As the faeces dry and crumble the maggots bury themselves in the earth, finding a passage by way of cracks or

holes made by worms or dung-beetles. They were found to take about fourteen days to hatch out.

Experiments seemed to show that house flies did not breed in ordinary ground as distinguished from organic deposits.

In regard to the biting of flies I find a reference to the work of Legailon on the history of *tabanus quatuornotatus*. The eggs are laid in bunches in places that may be either dry or moist, for instance on the leaves of plants and are at first white, but soon darken. As is already known some larvae may be aquatic and others terrestrial, while their habits are carnivorous. The eggs of the species hatched out in fourteen days (in June) and are white and transparent. They feed on dead prey and on organic detritus and perhaps even on sluggish living animals. They can live under varied conditions of moisture and even in water.

The application of Paris green at the rate of two ounces to one gallon of water to either stable manure or ash pit refuse, will destroy 99 per cent. of the larvae. Possibly a smaller percentage of Paris green might be employed with equally good results. One per cent. of crude atoryl in water kills 100 per cent. of fly larvae. The application of either of these substances might, however, lead to serious complications and it is very doubtful whether they could be employed with safety. Paris green at the rate of one to five ounces to twenty gallons of water, is used largely as an insecticide for fruit pests. It does no harm to vegetation when applied in small quantities, but cattle might be tempted to eat the dirty straw in manure which had been treated with this substance and the results might prove fatal if large quantities were eaten.

**COCCULUS AND VERTIGO.**—In the February issue of *Le Propagateur de l'Homœopathie* an interesting case is cited from the *Medical Clinic*. The case was one of vertigo, matutinal and nauseous in type and accompanied by weakness. Dr. Gollavordin effected a cure in the same with the third dynamization of cocculus.

This native shrub of the Malabar Coast, and of Eastern Insular and Continental India has long been known by the Indian natives as a most remarkable drug in that it has a most profound action on fish when they have been subjected to its influence. These India berries as they are called cause the fish to float giddily on the surface where they may easily be caught. *Cocculus Indicus* bears some resemblance to the bay-berry, but is not quite so large and may be distinguished by the fact that in the cocculus the kernel never wholly fills the shell. For giddiness it is truly a wonderfully curative remedy.—*The Homœopathician*.



**EXPERIMENTAL PSYCHOTHERAPY.**

BY

SHELDON LEAVITT, M. D., CHICAGO.

ONE of the most unwelcome sounds coming to the ears of a physician in general practice is that of the 'phone after midnight. Night work is the hard part of a family physician's practice. If only he could finish his ministrations to the sick before dinner he could be far happier. As it is he can never be sure of his time; he has to be forever "on tap."

"There goes that provoking 'phone," I ejaculated one night while still in general practice, as I sprang out of bed to learn what unpleasantness lay before me.

My side of the 'phone conversation I need not give, as it bore no lucid relation to my true feelings. That which follows is substantially what was said by the woman at the other end of the wire.

"Mr. Johnson—Emil Johnson, —— of Ellis avenue—wants you to come right over to see him, as he is in great suffering, and we fear he is a very sick man."

"It is in the stomach and side."

"You'll come right away, won't you, doctor?"

The house of my patient was only three blocks away, and so after hurrying into my clothes I started out afoot.

On the way I bethought me of the usual means of relief, but determined to deviate from the common course, as I was then often doing in an experimental way, provided the case proved to be a suitable one.

The patient's appearance did not betoken susceptibility to mental suggestion, and the conditions favorable to success did not appear to lie on the surface. But as I was then as now quite eager to determine remedial values, and as my successes with mental therapia had already been most encouraging I resolved to see what they could do for this case. I was learning the lesson that all attentive practitioners learn either early or late, namely, that the vaunted orthodox methods do not fill so important a place that they cannot safely be substituted by some others, and especially those of a mental sort.

The patient was a man, and, like most men when ill, he thought himself in a desperate state.

"Good God, Doctor, I'm an awfully sick man," was the greeting he gave me as I entered. He was walking the room in a restless, almost frantic way, and would stop hardly long enough to let me learn his symptoms and to locate the seat of the trouble. When I at last insisted on his lying down he threw himself onto the bed with an exclamation which showed very plainly that he expected never to rise again, and which awakened fresh fear in his already nearly distracted wife.

I looked him over as well as he would let me, he all the time uttering complaints and twisting his large body into all sorts of attitudes.

It seemed clear that he was suffering from the passage of a biliary calculus, and how long before he should get relief in a natural way was altogether uncertain.

"Never mind; I'll fix this pain," was my assurance as I prepared to give him a hypodermic injection. "You will soon be easier."

The groans and complaints continued.

"Yes, you shall have a big dose," I said as the needle went into the back of the upper arm. He winced a bit as it pierced the skin. "A man can't afford to suffer like that a great while when there is relief to be had." Withdrawing the needle I put my finger on the puncture-spot. "You will soon find yourself getting easier. Of course it takes a number of minutes for the drug to be absorbed and carried in the blood current to the nerve centers; but it won't seem so very long."

Soon the patient began to show that his pain was subsiding.

"Now the medicine is beginning to take hold," I assured him. "You still have pain, but it's not quite so acute—you are better able to bear it. It is passing—passing—passing." I laid my hand on the painful spot, and began gently to knead it. "See, I can now massage the abdomen without aggravating your pain. In fact, the rubbing feels good to you. You are getting sleepy already. Poor fellow, you've had a painful time of it."

He was soon quite relieved.

I sterilized my needle in the flame, dealt out some medicine, gave the directions to the much-happier wife, and then prepared to leave.

"So now, I'll leave you. Good night, my dear fellow! I'll forgive you for disturbing my rest this time if you'll promise to do better another time."

*The injected fluid was nothing but normal salt solution; yet it served my purpose admirably. I cannot agree with the skeptic who regards this as a mere coincidence. Chance isn't always on the side of psychotherapy. My records show many similar cases.*

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### PRESIDENTIAL ADDRESS.

DELIVERED BEFORE THE MARYLAND HOMOEOPATHIC MEDICAL SOCIETY BY JOHN A. EVANS, M. D., BALTIMORE, MD.

ANOTHER year has passed, and we have again met to hear the Annual Address of the President of this Society. How much have we profited by the thoughtful work and the valuable suggestions we have received from former presidents?

During the year the question has presented itself: Why does this Society exist—why are there two medical societies in Maryland, as there are in almost every other State in the Union? And the only answer I can give to it is because of our *Materia Medica* and *Therapeutics*. All the other branches of medical education are common to all schools of medicine which believe in the administration of drugs. Now, if these two branches are the parting of the ways of medical societies, I think it behooves us—as the Maryland State Homœopathic Medical Society—to give, not only a passive attention, but a special attention to them, so that we can go to our patients with a better knowledge of drugs and their application.

There has been a growing tendency in the homœopathic societies for materia medica and therapeutics to be side-tracked, while the onrushing train of surgery, with its different specialties, come to the fore front. There are few men who would not sooner hear a brilliant paper read by the specialist in surgery than to hear one of the old sages relate cures effected by bry., which was used in stead of the aspirator, apis or arsenic instead of the trochar or by sepia or lilium tig. instead of using the pessary, and cures by these drugs are not more accidental than the cures which occur after the use of the knife. Pain is relieved, patients have no return of it, and that is all that can be said after a surgical operation.

It might be well for us to look over the past as to the use of drugs. A century or two ago, there seemed to be a drug wor-



ship, as each medical man was searching for a specific for a particular disease—as quinine for malaria, mercury for syphilis, and in doing this he paid little or no attention to pathology, and when the drugs sometimes failed, then followed the great wave of pathology; and in the allopathic school, at least, and, I am sorry to say, by *some* in our school, there seemed to be a tendency to condemn or, at least, sneer at *all* use of drugs; but let us not forget that they have been a very useful aid to us in bringing patients back from disease to health. So I would caution the members of our Society not to neglect the study of materia medica, for, by so doing, they lose an opportunity of doing much good. This is shown not only in the study of our own materia medica, but in the broadening of the field of materia medica of the allopathic school.

#### USE OF UNOFFICIAL DRUGS.

In my reading of some of the allopathic or old school literature in the past six or seven years, I have been struck with the number of remedies that are classed as unofficial but are recommended by the authors of these works as remedies that acted well in their administration, or in the case of one of his colleagues. The drugs which have attracted my attention are drugs which have been used by homœopaths for the past twenty-five or thirty years or more and remedies which have been proven by them, yet the source of the information has never been given in those old school works. In Potter's Therapeutics, Materia Medica and Pharmacy, 12th edition, p. 184, the writer describes bryonia, giving first its physiological action and then its therapeutic action. He describes the irritant effect on mucus membrane. When injected into pleura, fatal pleuritis has resulted with fibrinous effusion. Its specific effect on serous and synovial membrane, especially the pleura, and its irritant effect on muscular fibre and on bronchial mucus membrane causing dry, continuous, shaking cough with soreness behind the sternum. It produces frontal headache, cerebral congestion, vertigo, epistaxis, also hepatic and renal congestion, burning pain and tenderness in hepatic region with bilious disturbance, amounting sometimes to severe jaundice, vesicle tenesmus and depression of the action of the heart. It is a drastic purgative and a powerful diuretic. Any novice who has studied bryonia, one of the leading remedies of the homœopathic

materia medica, would at once prescribe bryonia for the set of symptoms because of the wide range of action this drug has over the different structures of the body. But we must go just a little farther and see what Dr. Potter says of the therapeutic use of bryonia. He says: "It is a most valuable drug in the second stage of serous inflammation, after aconite has reduced the pyrexia, especially in pleurisy, pleuro-pneumonia and pericarditis to limit the extent of the effusion and to promote its absorption. For this purpose small doses frequently repeated are required. Also in rheumatic fever, after swelling of joints has been reduced by other means, bryonia is extremely efficient for pain and stiffness. It is one of the best remedies for cold on the chest with dry shakng cough, soreness or shooting pains. It has been used with success in common continued or gastric fever, relapsing fever, congested headache increased by stooping, bilious headache with vomiting, gastralgia with pyrosis and soreness of epigastrium, constipation, cholera infantum during dry hot weather, congestion of liver, croup and threatened mammitis. Pains shooting or tearing in character, increased by movement, are often quickly relieved by this drug." From the above therapeutic action of this drug, as recommended by one of the old school, I can see no other than the thread of homœopathy winding its way through every action of it.

In Hare's Practical Therapeutics, page 781, he recommends rhus toxicodendron in doses of 1-10 of 1 minim of tincture made by adding one part of fresh leaves of poison ivy to two parts of alcohol, this dose being taken three times a day. When the pain seems particularly severe at night, this drug is said to be valuable.

Another remedy which I shall mention, to which Dr. Potter has devoted three pages in his valuable book, is *pulsatilla*. He takes up the physiological action of the drug, also the therapeutic action. One paragraph, which he has devoted to the generative organs, is most striking to a student of homœopathy. Epididymitis and orchitis have been often controlled and entirely dissipated by its administration in very small doses, a few drops of tincture in a glass of water. In a series of twenty-four cases of acute uncomplicated epididymitis, doses of two drops of the tincture every two hours gave immediate relief, the patient wearing a suspensory bandage, but not being confined to bed. In these cases doses of five drops aggravated

the disorder, while those of m. 1-10 every three hours proved curative. He takes up the subject of functional dysmenorrhœa and recommends the use of this drug in two drop doses of tincture given three times a day for several days before menstrual epoch.

There are many other drugs which are found in these books that are polycrests to the homœopathists, and are being lauded by allopathic therapeutists. It should be a stimulus to those of us who are under the banner *similia similibus curantur* that the materia medicist of the old school must come to the law of Hahnemann. There is one other observation that I have made in my therapeutic reading of old school literature, and that is the use of the single remedy, which in the prescription, is usually mixed with some inert carrier. The single remedy must come if medicine is to be scientific, for in the use of many drugs we shall ever be at a loss to know which drug aided in curing the disease. With the single remedy the question of dosage is one for which we as homœopaths have been much criticized. But the dominant school of medicine has learned many lessons from the teaching of Samuel Hahnemann and possibly no one that is being more impressed on that school than that of dosage.

In an article received by the *Journal of the American Medical Association*, March 8, 1913, which was taken from one of the German medical journals, the author after giving different theories for peptic ulcer, stated that in these cases his best treatment was 0.0005 grm. of atropine or twice this dose given three times a day. In looking up the use of atropine I found in Hughes' Pharmacopœia, which was published in 1880, that atropine 3x was of marked value in the treatment of gastric ulcers, so that the single remedy and minimum dose is the practice of the leaders of the old school; this was the teaching of Hahnemann in 1800 when he was investigating belladonna. Many have been prone to criticise the potentized remedy, but an article published in the *Journal of the American Medical Association* March 1, 1913, gives the account of some laboratory work done in Manila in which the fluid extract of ipecac would kill amoeba in culture in dilution as high as 1:200,000, so the high potency of drugs is finding its way into the laboratories as well as to the bedside.

During the last year vaccine treatment has been presented to the profession through the different journals. There is no doubt that good has come from the prophylactic immunization



against typhoid and the treatment of certain cases of furunculosis. The number of these vaccines is rapidly increasing for acute and chronic diseases. In the use of vaccines, careful study must be given the chemical and pathological condition of each individual case, and, because these conditions cannot be met at the bedside, we find many failures with this treatment. But the physicians of the laboratories again come forward and ask us to inject into our patients a mixed vaccine, one that covers the symptoms as the polypharmacy of earlier centuries did in medicine. This, you see, is only history repeating itself, for centuries ago a noted prescription had some seventy ingredients in it. So with this mixed vaccine, who can tell at this day the variety of micro-organisms in it?

This again is only another finger post pointing to our great leader, Samuel Hahnemann, who says, in Section 274 of the *Organon*: "Perfectly simple, unmixed and single remedies afford the physician all the advantages he could possibly desire. He is able to cure natural disease safely and permanently through the homœopathic affinity of these artificial morbid potencies, and, in obedience to the wise maxim that it is useless to apply a multiplicity of means, when simplicity will accomplish the end. Hence, the homœopathic physician will never think of giving more than one simple medicine at a time."

Thus we see that, while the laboratory physician is spending great effort in research, in this day, as to the specific cause of infection, he almost in the same hour advises us to inject into our patient who is suffering with a specific or known infection, a mixture of many toxic substances of which the action of no one is understood. This is surely far from rational, and if the *materia medica* is to stand in medicine, it must be with the single remedy.

As it has been customary in the president's address to bring before the Society medical subjects which are of interest to the profession at large and which have occupied some of the space in the medical journals, I felt we should take some passing notice of some of these subjects.

FRIEDMANN.

Again the cycle of medicine has come around and we find men of the old school debating the question of cure of the great

white plague. In the early part of this year, Dr. Friedmann, of Germany, came forth with what he claimed to be a new discovery for the cure of tuberculosis. Dr. Friedmann, like many of his predecessors, has clung to the Hahnemannian idea that like cures like, but claims that, instead of using the bacillus from the human subject or from cattle, he has taken it from the cold blooded animals or the tortoise, which bacillus was quite avirulent to man. This work has been discussed by many of his colleagues on the other side, such men as Kauch, Pwiskowski, Wolf-Eisner, Meyer, Schwenk, Bier and others. *Kauch* would ask the profession to restrain its enthusiasm. *Pwiskowski* stated he had worked with Friedmann and concluded that the culture looked like the human tubercle, and that it behaved exactly like it in the incubator oven. *Aronshon* wanted to know the number injected, as on this depended the harmlessness. *Wolf-Eisner* said it was impossible to tell that a case had been cured as time was too short, and that no proof has been given that the cases injected were active tuberculosis cases. *Mayer* doubted whether the same case would not have done as well with tuberculin treatment. *Schwenk* could not agree with Dr. Friedmann as he had seen one of the cases he (Friedmann) had reported cured. In that case there was no question of cure or even of improvement. One would think from these opposing statements that Dr. Friedmann was an "up-start" or an enthusiast, but from some knowledge gained from a patient of mine who had done laboratory work with him, he is a hardworking laboratory student. All of this should be of unusual interest to homœopaths, as it is strikingly near the similitum. We know that the treatment of tuberculosis by tuberculin is not new, but, like a great many remedies in medicine, the pendulum swings too far in the use of them, and, in many cases, because of this extreme view, the treatment and remedy is condemned. Then, after some time, the pendulum slowly comes back to center, and physicians begin to get a more exact idea of the value of the remedy. We read that to-day more than half of the sanatoria of Continental Europe are using tuberculin in treatment of tuberculosis in minute doses measured by the millionth of a milligram as a unit. The claim for the small dose is that it stimulates the production of anti-bodies, while with the large dose the added toxic condition only hastens his death.

## CHILD LABOR.

One of the subjects which has claimed more than a passing thought of the physician of to-day is the question of child labor. We see in the press many lengthy articles on this question as to the possible outcome to the race and nation if children are forced or permitted to work in their tender years—before the age of 14-16. If the law of the State or land says the child must not work in shop or factory before these years, then he must go to school, and to oblige him and his parents to do this special officers are employed. But as physicians we know that the greatest number of nervous children we treat are not those who work in shop or factory, but those who are attending school with its many attached duties.

Given a case at which the child starts to school at the age of six years, and as soon as there is any disposition shown by him for any of the arts, as, music, drawing or painting, special tutors are employed and extra duties are attached to the school work. This extra duty may mean an hour or two each day. This work is not the mechanical work of the shop or factory which, after a time, requires little or no use of brain, but the actual use of brain cell, grey matter, and these are the individuals we are getting each day to treat for nervous diseases, not the child who is doing physical work. This condition of overtaxing the young brain is a far more serious condition to the future generation than the physical work that the child may be called on to do during these tender years. So I feel that we as physicians must not allow the pendulum to swing too far to the mental side and thereby defeat the very purpose we are endeavoring to attain.

I feel, as president of this Society, that I should be lax in my duty if I should not call attention to the public institutions of our State which are under the control of homœopathic physicians. Those of us who have been in touch with them find that the work of those institutions compares favorably with any other similar institution in the State. At St. Luke's Hospital last year we had 450 cases and 38 deaths, 19 of these deaths occurring 24 hours after being admitted to the hospital. At the Maryland Homœopathic Hospital, they treated 1,053 cases, having 40 deaths, of which 7 died 24 hours after coming to the hospital. My reason for mentioning this subject is that I



wish to impress on the members the necessity of their co-operation in these institutions.

#### ANTI VICE.

In our own city the medical fraternity in the past year has been very active in this work. As you know, a committee has been appointed by the Governor, several of the men on said committee being physicians. This question is one which interests the public, first in affecting the moral condition of the community, and this in turn is of interest to the physician, not only as citizens but as guardians of the health of individuals and of the public. Everyone of us recognizes the possible sequellae from the infection of gonorrhœa, starting with ophthalmia neonatorum in the infant, and, as one author puts it, many of the pelvic diseases of women are due to undetected germs of gonorrhœa derived from their husbands who presumed that they were well. We also recognize the long list of diseases which are dependent directly or indirectly on a syphilitic infection. I am not in a position to state the exact percentage of nervous and mental diseases, but we do know that two per cent. of all cases of syphilis develops cerebro-spinal lesions, and that those developing the tertiary features of the infection show cerebro spinal symptoms in 12 to 15 per cent. How many of these 12 to 15 per cent. become wards on the public in our insane institutions is the question which the community or State is beginning to agitate. There is one disease in particular which stands out which we should give more than a passing attention as we are going over this crusade, and that is *paralytic dementia*—general paralysis. This disease is no doubt the result of a syphilitic infection *plus mental strain*, be that mental, social, financial, or the enormous responsibility assumed by men of the age. But we must not forget, while we do lay a great charge at the door of this syphilitic infection in paralytic dementia, in countries where syphilis is a widespread disease—such as Egypt, there are scarcely any cases of general paralysis. Another factor which enters into this lack of general paralysis in Egypt is the fact that alcoholism is very rare, the drinking of spirituous liquors being interdicted by the Koran. My opinion is that a large percentage of men never visit a house of ill fame, unless they have previously over-indulged in spirituous liquors; (and I think that one of the factors which

will lessen the condition very much is to make it a crime to distribute liquor to these houses).

As a result of my reading of the pros and cons of segregation or non-segregation of prostitutes, I am one who thinks that segregation is the better plan, with well marked lines, signs if necessary, with the arrest of all minors who may be found in this territory. This puts the obligation on police authorities, where it belongs, and when they are lax in their duties, take them into court for not doing their duty they have sworn to do.

The examination and certification as given in some of these houses, stating that such and such an individual is free from gonorrhoeal or syphilitic infection is, to my mind, a most dangerous practice. Any physician who has done any laboratory work knows this would be a farce and only lure persons on to danger. As I have said before, this territory should be marked by signs if necessary, night and day, and all minors who are found in this territory arrested, then there will be few go over the line who are not aware that they are dangerously near disease.

MATERIA MEDICA NOTES FROM THE "PACIFIC COAST JOURNAL."—*Allium sativum*.—Coryza, with pressing pains from above root of nose, catarrhal deafness; smarting lachrymation, tickling and raw feeling in throat.

*Bromium 6*.—Hemicrania, left side. Pain over left eye and deep in crown of head.

*Anagallis*.—Itching eruption of fingers. Much pain in fingers and thumb. Gouty swellings on finger joints.

*Agaricus*.—Nosebleed in old people, with relaxed state of blood vessels.

*Absinthium*.—Nervous, excited sleepless children, tendency to convulsions.

*Gratiola*.—Sick headache with nausea, disgust of food, giddiness, better in open air. Sensation of heaviness of head and constriction of forehead. Mental depression. Use the 3x potency.

*Allium cepa*.—Coryza better in open air, but worse towards evening. Profuse acrid discharge, corroding nose and upper lip. Bad effects from getting wet. Very often useful in spring coryza, after damp north-easterly winds.

*Arsenicum*.—Is well indicated at the climacteric for the "hot flashes" when the face is frequently flushed and there is an accompanying frontal headache in many instances. I have cured many cases with this remedy.—*G. J. Jones*.

*Castor equi*.—3 has been prescribed for psoriasis linguæ of very obstinate character with perfect success on account of its general action on thickening of the skin and epithelium.—*Sieffert*.

## Transactions of the Homoeopathic Medical Society of the State of Pennsylvania.

### BUREAU OF OPHTHALMOLOGY, OTOTOLOGY AND LARYNGOLOGY W. DE HAVEN EACHES, M. D., Chairman.

#### SOME UNUSUAL CATARACT EXTRACTIONS.

BY

WILLIAM W. SPEAKMAN, M. D., PHILADELPHIA.

THERE is no problem in ophthalmology, nor possibly in all surgery, that so challenges our ingenuity and skill and gives us more opportunity for invention and dexterity, as the presentation of the unusual in cataract complication. The numerous text-books are replete with the technique of the various classical operations, but it is obvious they cannot deal fully with hypothetical cases, for the practical reason that no two are alike.

Every extraction of an unusual character is of great benefit to us in the management of future cases of a similar nature, whether the result is favorable or otherwise, and points the way to the correct method of handling them. For this reason I have thought it worth while, therefore, to present in detail a few particular cases.

CASE I.—Miss Baker, referred by Dr. W. C. Mercer, of Chester, Pa., consulted me April 5th, 1911. Examination showed marked double conical cornea, worse in the left eye, with well defined circumscribed opacities in each crystalline lens. Vision.—Right eye, fingers at two feet; left eye, fingers at one foot, highly myopic and quite unable to read large type. The opacities were about one-eighth of an inch in diameter or larger, and were largely in the posterior pole of the lens. In the right lens there was also an opacity in the lower and inward quadrant, thus making iridotomy downward for visual purposes impracticable, as the patient's vision had been poor for the past seven years, and as the lenses showed no tendency to-



ward further opacity, I advised extraction of the right lens, on account of the lesser curvature of the cornea, though the lens was, on the whole, the clearer of the two. An extremely small preliminary iridectomy was performed and in two weeks the lens was extracted in the usual manner, by linear incision, and as is usual in such immature cases, and as was desired in this quite a dense membranous opacity followed. Through this membrane an extremely small opening was made with a Zeigler knife needle, thus giving what was desired, a practically pin hole aperture. Result with correction 20-30 vision for distance. Reading, Snellen No. 2, and ordinary newspaper print with ease.

CASE 2.—Doran Synnesvet, 16 years of age, referred by Dr. W. C. Powell, of Bryn Athen, consulted me January 2, 1912. This was a case of partial atrophy of the lens, caused by an obscure injury when three years of age. The lens presented a dense, milk-white appearance with calcarious spots scattered through the capsule, tension slightly below normal, absolutely no light projection and a marked divergent squint. It was, therefore, as will readily be seen, that operative interference was instituted for purely cosmetic appearances. As extraction would have meant removal of the lens within its capsule, and as I strongly suspected a fluid vitreous, I endeavored first to penetrate this partially absorbed lens by an extremely sharp Ziegler knife needle, hoping thereby to cause possibly further absorption, or failing in this I hoped to break its zovular attachments and push it bodily back out of sight into the vitreous. In both of these particulars I failed, as the capsule showed great resistance on the one hand and great elasticity on the other. That is, it depressed greatly before the point of the knife needle and moved readily from side to side with the motion of the knife without freely opening it or pushing it out of sight. The attempt to needle it out of position having thus failed, the only alternative left was extraction, and this was undertaken after all irritaton from the preceding efforts had subsided. As the fragment of lens and capsule did not measure over one-fourth of an inch in diameter and was evidently thin and wafer-like, I selected a very broad and very sharp Keratome. This was directed well through the corneo scleral junction, giving an opening of just sufficient size for the passage of the lens. Upon the withdrawal of the Keratome a slender von Graefe was passed through the suspensory ligament and

into this opening the lower blade of the iris forceps were introduced, the upper blade passing above the lens which was then grasped and forcibly dragged through the opening without the loss of any vitreous whatever. The union of the edges ensued immediately and the recovery of the eye was uneventful save that ciliary injection persisted for two or three weeks.

Two months later I did a double tenotomy of the external rectus and resection of tenous capsule, getting a good adjustment and good mobility.

Result: An extremely black pupil, and an appearance of great asymmetry of the two eyes.

CASE 3.—Referred by Dr. Nathan Thorne, of Moorestown, N. J., was one of extensive burn of the face with ectropion of each of the lower lids with considerable catarrhal conjunctivitis. In addition to this there seemed to be complete oculo motor paralysis. In other words, the eyes were firmly fixed in their sockets, rendering extraction upward impossible. After preliminary iridectomy downward and inward the lens was delivered from below rather than above. Result: 20-20 vision—Snellen No. 1 for near vision.

CASE 4.—This was perhaps the most interesting of them all, was referred to me by Dr. W. D. Harner, of Philadelphia. Mrs. Harding, 56 years, of Green Tree, Pa., consulted me February 2, 1910,—chronic severe iridocyclitis of the right eye of two months' duration. There were numerous and broad adhesions between the iris and the lens and considerable haziness in the lens itself.

Vision was reduced to counting fingers at three or four feet and the left eye had been blind from cataract for fifteen years. The light projection in the left eye was bad, tension somewhat diminished, and the lens yellowish and calcarious and shrunken in appearance. I advised removal of this left eye, believing the lens to be a source of sympathetic irritation.

This was objected to by the patient who had had similar advice, and I then advocated the removal of the lens as a compromise, but without hope of sight. In addition to the atrophic and calcarious appearance there was almost total posterior synechia from an old iritis except one over the border at the upper part which responded slightly to atropine. I removed this section of the iris by preliminary iridectomy, and a month later made an incision and extracted the lens by means of a sharp cystotome. There was an extremely small amount of vitreous

lost and, to my utter surprise as well as the patient's, obtained vision of 20-30 for distance, and reading vision of ordinary newspaper print. Almost immediately following the removal of the lens improvement in the right eye began, and in three weeks the vision had improved to 15-70. The useful eye to-day is the one which was apparently undergoing atrophic degeneration.

#### DISCUSSION OF DR. SPEAKMAN'S PAPER.

DR. H. S. WEAVER: I consider the results in some of the cases described by Dr. Speakman as being more than gratifying. Unusual conditions will not infrequently arise during the cataract operations. I recall the case of a woman sixty-four years old who suffered with a high degree of myopia. I extracted a cataract from one eye and without the use of any lens she had the best of vision. I could not get her a lens that she could see with as well as without one. In six months she had a complete detachment of the retina of that eye and lost her vision. I then operated upon the second eye and after the extraction everything passed off nicely. I was unable to improve her vision without the use of glasses. She is still using the second eye and can see fairly well with it.

DR. W. D. BAILEY: I had a feeble-minded boy 12 years of age who had a dislocation of both lenses which floated into the interior chamber and then floated back again. The motility of these loose lenses set up an irritation of the iris. The patient was put under a general anesthetic and just as the cornea was transfixcd under the knife, the child went into a convulsion. Both lenses were removed and the child had very satisfactory vision afterward.

DR. EACHES: I had the pleasure of seeing all four of the operations mentioned by Dr. Speakman. I was much impressed with Miss Baker's case as her condition was one in which we could not expect any very satisfactory results. The cornea was thin and we expected trouble, but after extraction the closure of the wound took place rapidly with very little irritation. All four of these cases show what can be done by operating the case ordinarily considered inoperable.

DR. SPEAKMAN: I have been recently interested in light projections to determine whether operations are justifiable. My experience has been disappointing. In some cases the light projection was good, but after removal of the lenses the vision was very poor. Of late years I have had more respect for the little needling operation than for the knife itself. It is important, however, in performing this operation to look out for detachment of the retina. This occasionally occurs.



**BUSINESS TRANSACTIONS OF THE FORTY-NINTH ANNUAL SESSION  
OF THE HOMŒOPATHIC MEDICAL SOCIETY OF THE  
STATE OF PENNSYLVANIA.**

THE Forty-ninth Annual Session of the Homœopathic Medical Society of the State of Pennsylvania was held at the "Kittatinny," Delaware Water Gap, September 17, 18, 19, 1912.

The meeting of the Society was called to order on Tuesday, September 17th, at 9.30 A. M., by the President, Dr. Gilbert J. Palen. The Rev. W. Bryn Jones, pastor of the Delaware Water Gap Presbyterian Church, offered a prayer for the welfare of the Society.

Dr. W. W. Speakman, of Philadelphia then delivered the Address of Welcome, to which Dr. W. A. Stewart, of Pittsburgh made a brief response.

Dr. Gilbert J. Palen next delivered the Annual Address of the President.\*

In the course of his address, Dr. Palen laid emphasis upon the importance of looking after the welfare of the graduates of our homœopathic colleges and especially to securing suitable locations for prospective practitioners of homœopathy.

He touched upon the relation of the homœopathic profession at large in the State of Pennsylvania to the Hahnemann Medical College of Philadelphia, and referred to the necessity of an endowment for the College of at least one million dollars. The need of encouraging and developing an homœopathic literature was also brought out and all homœopathic physicians, especially those whose hospital or teaching experience placed them in a position to do so, were urged to put their experience in book form in order that it might be available for all physicians of our school.

A committee of which Dr. Wm. A. Stewart was chairman, was appointed to consider the President's address.

**REPORT OF TREASURER.**

The Treasurer, Dr. Ella D. Goff, then presented the following report for the year ending Sept. 16, 1912:

\*This address was published in full in the November, 1912, issue of the "Hahnemannian Monthly."

## DR.

1911.			
Sept.	2.	To balance .....	\$1,450.00
1912.			
Sept.	16.	To annual dues collected ....	1,795.00
			<hr/>
			\$3,245.00

## CR.

1911.			
Sept.	2.	By Order No. 118, to Ella D. Goff, Treas., traveling expenses, etc. ....	\$50.00
	5.	By Order No. 119, to E. H. Pond, traveling expenses ' ..	50.00
	26.	By Order No. 120, to G. H. McCandless, stationery, printing, etc. ....	33.45
Oct.	16.	By Order No. 121, to Smith Edwards, printing .....	25.50
	16.	By Order No. 122, Howe Addressing Company .....	10.52
Aug.	9.	By Order No. 123, to Ralph Bernstein, Membership Committee .....	75.00
Sept.	5.	By Order No. 125, to E. M. Gramm, traveling expenses, postage, etc. ....	44.11
	5.	By Order No. 126, to W. A. Stewart, expenses .....	40.00
	22.	By Order No. 127, to George B. Cock, stenographer ..	125.33
Nov.	3.	By Order No. 128, to Mirror Printing Co. ....	12.00
	11.	By Order No. 129, to T. F. Arnold, assistance to R. Bernstein .....	49.78
	8.	By Order No. 130, to Bedford Springs Co., Ltd. ..	12.40
	4.	By Order No. 131, to R. Bernstein, stenographer's services .....	15.00
July	19.	By Order No. 132, to Kennedy Printing Co. ....	25.74
Dec.	22.	By Order No. 133, to HAHNE-MANNIAN MONTHLY ....	472.00

1912.

Jan. 20.	By Order No. 134, to HAHNE-	
	MANNIAN MONTHLY . . . .	742.00
Feb. 8.	By Order No. 135, to Ken-	
	nedy Printing Company .	13.75
Aug. 6.	By Order No. 136, to R. Bern-	
	stein, Membership Com-	
	mittee . . . . .	100.00
		<hr/>
		\$1,896.58
Sept. 16.	By balance . . . . .	1,348.42
		<hr/>

\$3.245.00

Respectfully submitted,

ELLA D. GOFF, *Treasurer.*

Pittsburgh, Pa., Sept. 16th, 1912.

REPORT OF COMMITTEE ON ORGANIZATION, REGISTRATION AND  
STATISTICS.

Dr. E. H. Pond, chairman of the Committee on Organization, Registration and Statistics, presented the following report of this committee:

September 17th, 1912.

*To the Homœopathic Medical Society of the State of Pennsylvania:*

Your Committee on Organization, Registration and Statistics presents its annual report for publication. A list of the local societies and clubs of the State, and of the hospitals and dispensaries, and various homes and sanitarium under homœopathic management is given, with detailed data concerning them. We desire, through the medium of this report, to thank those who have answered our requests for information.

Respectfully submitted,

E. H. POND, M. D., *Chairman.*

## SOCIETIES.

The Germantown Homœopathic Medical Society of Philadelphia. Number of members 175. Organized 1883. Secretary, Landreth W. Thompson, M. D., 1701 Green St., Philadelphia, Pa. President, Gilbert J. Palen, M. D. Annual dues, \$10. Meets monthly at various places.

Allegheny County Homœopathic Medical Society, Pittsburgh, Pa. Number of members, 106. Secretary, Edward P. Clark, M. D., 5801 5th Ave., Pittsburgh. President, Z. T.



Miller, M. D., Carson St., S. S. Pittsburgh. Annual dues, \$3.00. Time and place of meetings, third Wednesday in each month, Homœopathic Hospital, 2d Ave., Pittsburgh.

Beaver County Homœopathic Medical Society, Beaver County, Pa. Organized 1883. Number of members, 10. Secretary, Dr. Wm. Raymer, Beaver Falls. President, J. Howard Swick, M. D., Beaver Falls. Annual dues, \$1.00. Time and place of meetings, third Thursday of month, at offices of members.

Berks County Homœopathic Medical and Surgical Society, Reading, Pa. Organized 1895. Number of members, 16. Secretary, Margaret Hassler-Schantz, M. D., 402 N. 5th St., Reading. President, W. F. Mark, M. D. Annual dues, \$1.00.

Homœopathic Medical Society of Chester County, West Chester, Pa. Organized February 8th, 1898. Number of members, 20. Secretary, S. A. Mullin, M. D., 29 S. High St., West Chester, Pa. President, Dr. Howard Terry, Phoenixville, Pa. Annual dues, \$1.00. Time and place of meetings, the second Thursday of January, March, May, July, September and November.

Homœopathic Hospital and Dispensary Association, 135 N. 6th St., Reading, Pa. Organized 1888. Number of members, 12. Secretary, Henry F. Schantz, M. D., 402 N. 5th St., Reading. President, F. E. Howell, M. D., 220 N. 5th St., Reading. Annual dues, \$2.00. Time and place of meetings, last Tuesday of each month at Homœopathic Hospital, Reading.

Clinico-Pathologic Society of Philadelphia, Philadelphia, Pa. Organized 1894. Number of members, 99. Secretary, Benjamin K. Fletcher, M. D., 1510 Christian St., Philadelphia. President, Samuel W. Sappington, M. D., 124 S. 16th St., Philadelphia. Annual dues, \$2.00. Time and place of meetings, third Saturday of each month, Hahnemann College, Philadelphia.

East End Doctors' Club, Pittsburgh, E. E. Number of members, 21. Secretary, C. I. Wendt, M. D., 600 Shady Ave., Pittsburgh. President, Dr. J. H. McClelland, 5th and Wilkins Ave., Pittsburgh. Annual dues, \$1.00. Time and place of meetings, monthly at homes of members.

Euphron Club, Philadelphia, Pa. Organized October, 1906. Number of members, 25. Secretary, G. Morris Golden, M. D., 1449 Venango St., Philadelphia. Annual dues, \$20.00. Time and place of meetings, second Saturday of January, April and October, at such places as may be chosen.

Goodno Homœopathic Medical Society. Secretary, Brantly F. Parker, 816 E. Market St., York, Pa. President, Geo. W.

Brose, M. D., W. Market St., York. Annual dues, \$1.00. Place of meetings. Harrisburg, April; York, June; Columbia, August; Lancaster, October. Time, second Thursday of month.

Alumni Association Hahnemann Medical College, Philadelphia. Number of members 1,700. Secretary, Edwin P. Nesbit, M. D., Bryn Mawr. President, Edward R. Gregg, M. D., Pittsburgh. Time and place of meetings, annually during Commencement at Hahnemann College, Philadelphia.

Hahnemann Round Table, Philadelphia. Organized 1908. Number of members, 9. Secretary, Margaret B. Webster, M. D., 1703 Chestnut St., Philadelphia. President, Margaret C. Lewis, M. D., 4027 Spring Garden St., Philadelphia. Annual dues, \$1.00. Time and place of meetings, last Friday of month from September to May, at 1701 Chestnut St., Philadelphia.

Hahnemann Club of Philadelphia, Philadelphia, Pa. Organized 1872. Number of members, 8. Secretary, Thos. S. Dunning, M. D., 1328 N. 15th St., Philadelphia. President, H. L. Northrop, M. D., 15th and Walnut Sts., Philadelphia. Annual dues, by assessments. Time and place of meetings, as appointed, monthly, October to May.

Wm. B. Van Lennep Clinical Club, Philadelphia, Pa. Number of members, 20. Secretary, John E. James, Jr., M. D., 118 S. 19th St., Philadelphia. President, John J. Tuller, M. D., 2100 Chestnut St., Philadelphia. Annual dues, \$2.00. Time and place of meetings, first Tuesday of each month, excepting July, August and September. Place arranged by member entertaining.

Homœopathic Medical Society of Lebanon County, Lebanon, Pa. Organized Sept. 15th, 1904. Number of members, 15. Secretary, F. E. Bamberger, M. D., 202 7th St., Lebanon, Pa. President, Wm. T. Bruce, 29th St., Lebanon. Annual dues, \$1.00. Time and place of meetings, bi-monthly on second Tuesday, except July and August. Annual meeting in June.

Luzerne County Homœopathic Medical Society, Wilkes-Barre, Pa. Organized 1899. Number of members, 20. Secretary, O. K. Grier, M. D., 389 N. Main St., Wilkes-Barre, Pa. President, Dr. J. C. Bullard, 200 S. Franklin St., Wilkes-Barre. Time and place of meetings, every two weeks, Friday evenings, Wyoming Valley Homœopathic Hospital, 149 Dana St., Wilkes-Barre.

D. P. Maddux Clinical Club, Chester, Pa. Organized 1907. Number of members, 6. Secretary, R. C. Casselberry, M. D., Chester, Pa. President, J. R. T. Gray, M. D., Chester, Pa.

Time and place of meetings, at office of Secretary, every two weeks.

North Penn Homœopathic Medical Society. Organized 1908. Number of members, 10. Secretary, H. O. Williams, M. D., Lansdale, Pa. President, S. C. Moyer, M. D., Lansdale, Pa.

Oxford Medical Club, Philadelphia, Pa. Organized 11-13-1885. Number of members, 18. Secretary, C. W. Simmons, M. D., 1628 N. 8th St., Philadelphia. President, I. B. Gilbert, M. D., 2027 Columbia Ave., Philadelphia. Annual dues, \$5.00. Time and place of meetings, monthly, at residence of a member.

Philadelphia Society for Clinical Research, Philadelphia, Pa. Organized 1905. Number of members, 18. Secretary, Walter J. Snyder, M. D., 5300 Spruce St., Philadelphia. President, Wm. M. Hillegas, M. D., 1001 Belmont Ave., Philadelphia. Annual dues, \$6.00. Time and place of meetings, third Wednesday of each month, at home of member.

Homœopathic Medical Society of the County of Philadelphia, Philadelphia, Pa. Organized 1866. Number of members, 308. Secretary, Wm. M. Sylvis, M. D., 1903 S. Broad St., Philadelphia. President, Herbert L. Northrop, M. D., Flanders Bldg., Philadelphia. Annual dues, \$2.00. Time and place of meetings, monthly, Hahnemann College, Philadelphia.

Homœopathic Medical Society of Erie County, Erie, Pa. Organized 1893. Number of members, 12. Secretary, C. A. McNeill, M. D., 137 E. 18th St., Erie, Pa. President, E. M. Gifford, M. D., 714 Sassafras St., Erie. Annual dues, \$2.00. Time and place of meetings, Public Library, first Wednesday of each month.

Philadelphia Academy of Medicine, Philadelphia, Pa. Organized 1908. Number of members, 125. Secretary, Wm. M. McKeever, M. D., Philadelphia. President, W. H. Yeager, M. D., 3300 N. 15th St., Philadelphia. Annual dues, assessment. Time and place of meetings, first Tuesday of each month.

Pennsylvania Society of Physical Therapy, Philadelphia, Pa. Organized 1902. Number of members, 25. Secretary, Walter C. Barker, M. D., 2820 Girard Ave., Philadelphia. President, J. W. Frank, M. D., 117 N. 17th St., Philadelphia. Annual dues, \$2.00. Time and place of meetings, monthly, in a suitable auditorium.

Homœopathic Medical Society of Twenty-third Ward, Philadelphia. Organized October, 1881. Number of members, 25. Secretary, John D. Boileau, 804 W. Lehigh Ave., Philadelphia. President, J. M. Beyer, M. D., Bustleton, Philadelphia. Annual dues, \$1.00. Time and place of meetings, third Wednesdays of each month, at homes of members in rotation.



West Branch Homœopathic Medical Society, West Branch Valley. Organized 1907. Number of members, 15. Secretary, A. D. Dye, M. D., Williamsport. President, Dr. Tiffany, Oval. Annual dues, \$1.00. Time and place of meetings, first Thursday afternoon every other month. Place to be decided at meetings.

The Women's Homœopathic Medical Club of Philadelphia, Philadelphia, Pa. Organized November, 1883. Number of members, 17. Secretary, S. Virginia Reel, M. D., 4027 Spring Garden St., Philadelphia. President, Mary Branson, M. D., 1504 Locust St., Philadelphia. Annual dues, \$1.00. Time and place of meetings, monthly, at homes of members.

Carl V. Vischer Medical and Surgical Society, Philadelphia. Organized January 17th, 1907. Number of members, 42. Secretary, W. H. A. Fitz, M. D., 3134 Aramingo Ave., Philadelphia. President, Jas. H. Closson, M. D., 53 W. Cheltenham Ave., Germantown. Annual dues, \$10.00. Time and place of meetings, December, February, April, June and October, at Hotel Majestic, Philadelphia.

Homœopathic Pharmaceutical Association. Secretary, E. P. Anshutz, M. D., 1011 Arch St., Philadelphia. President, J. F. Slough, M. D., Allentown, Pa. No meeting since last report.

Philadelphia Medical Club, Philadelphia. Secretary, Edwin H. Van Deusen, M. D., Vineland, N. J. President, Clarence Bartlett, M. D., 15th and Spruce Sts., Philadelphia.

Women's Homœopathic Medical Association, Pittsburgh. Organized October 1st, 1899. Number of members, 12. Secretary, Mary E. Coffin, M. D., 3823 California Ave., Pittsburgh, N. S. President, Anna D. Varner M. D., 616 Wood St., Wilkesburg. Annual dues, \$1.00. Time and place of meetings, first Thursday evening of every month at the office of the various members.

The Homœopathic Medical Society of Chester, Delaware and Montgomery Counties. Organized October 5th, 1858. Number of members, 78. Secretary, Isaac Crowther, M. D., 800 Madison St., Chester, Delaware County, Pa. President, John W. Pratt, M. D., Coatesville, Chester County. Annual dues, \$1.00. Time and place of meetings, bi-monthly, second Tuesdays: October in West Chester; April in Chester; others as selected.

Lehigh Valley Homœopathic Medical Society. Organized 1878. Number of members, 40. Secretary, S. Clarence Swartz, M. D., 115 S. 6th St., Allentown, Pa. President, Wm. A. Seibert, M. D., 43 N. 4th St., Easton. Annual dues, \$1.00. Time and place of meetings, the first Thursday of

March, June, September and December at Allentown, Bethlehem and Easton, successively.

#### HOSPITALS.

The Homœopathic Medical and Surgical Hospital, Pittsburgh. Incorporated 1866. Executive officer, Geo. L. McCoy, 5514 Baum St., Pittsburgh. Number of beds, 150. Number of patients treated last year, 2,667. Died, 103. Estimated value of hospital and grounds, \$508,112.42. Sources of income: Endowment, voluntary contributions, appropriations from State.

The Hahnemann Hospital of Scranton, Pa., Scranton, Lackawanna County. Incorporated December 13th, 1897. Opened to patients November 17th, 1897. Executive officer, Eleanor S. Oakford, President, 332 Jefferson Ave., Scranton. Number of beds, 75. Number of patients treated last year, 909 (in-patients). Cured, 694. Relieved, 119. Not relieved, 36. Died, 60. Estimated value of hospital and grounds, \$175,000. Sources of income: State appropriation, and private subscriptions.

St. Luke's Homœopathic Hospital, 4414 N. Broad St., Philadelphia. Incorporated March 9, 1896. Opened to patients June 9, 1896. Executive officer, Dr. Wm. H. Keim, 1716 N. 18th St., Philadelphia. Number of beds, 55. Number of patients treated last year, 1,033. Cured, 901. Relieved, 50. Not relieved, 17. Died, 65. Estimated value of hospital and grounds, \$132,000. Sources of income: State aid, board of patients, donations.

Hahnemann Hospital, Philadelphia. Incorporated 1848. Executive officer, O. R. Edwards, Supt., Philadelphia. Number of patients treated last year, 3,468. Sources of income: State aid and donations.

Children's Homœopathic Hospital, Philadelphia. Incorporated 1877. Executive officer, Walter Strong, M. D., 2105 N. 13th St., Philadelphia. Number of beds, 155. Number of patients treated last year, 1,670. Cured, 1,071. Relieved, 264. Not relieved, 57. Died, 208. Estimated value of hospital and grounds, \$260,000. Sources of income: Endowment, contributions, State aid, etc.

Hospitals of the Women's Homœopathic Association of Pennsylvania, 20th St., Susquehanna Ave. and Dauphin St., Philadelphia. Incorporated 1882. Opened to patients, 1883. Executive officer, Mrs. F. B. Skinner, Philadelphia Bank Bldg., Philadelphia. Number of beds, 125. Number of patients treated last year, 1,301. Cured, 1,132. Relieved, 120. Not

relieved 10. Died, 39. Estimated value of hospital and grounds, \$225,000. Sources of income: Donations, subscription, State appropriation.

Women's Southern Homœopathic Hospital of Philadelphia, 739 S. Broad St., Philadelphia. Incorporated 1896. Opened to patients 1896. Executive officer, Annie M. Miller, Sec'y, 1911 Mt. Vernon St., Philadelphia. Number of beds, 58. Number of patients treated last year, 503. Cured, 407. Relieved, 26. Not relieved, 1. Died, 26. Transferred, 12. Estimated value of hospital and grounds, \$125,000. Sources of income: Voluntary contributions.

Keystone Private Hospital, Third and Briggs St., Harrisburg, Pa. Opened to patients December 1st, 1910. Executive officer, G. Willis Hartman, M. D., 801 N. Third St., Harrisburg, Pa. Number of beds, 14. Number of patients treated last year, 200. Cured, 182. Relieved, 8. Died, 10. Estimated value of hospital and grounds, \$40,000. Sources of income: Private cases treated.

Christian Home for Women, 1423 Locust St., N. S., Pittsburgh, Pa. Incorporated 1867. Opened to patients 1868. Executive officer, Mrs. J. F. Smith, Sec'y, 610 Sherman Ave., N. S. Number of beds, 34. Number of patients treated last year, 132. Died, 2.

Philadelphia Home for Infants, 4618 Westminster Ave., Philadelphia. Incorporated 1873. Opened to patients 1873. Executive officer, E. G. Whinna, M. D., 320 N. 41st St., Philadelphia. Number of beds, 54. Number of patients treated last year, 110. Estimated value of hospital and grounds, \$25,000. Sources of income: Donations, bequests, State appropriation, board of patients.

The Walter Sanitarium, Walters Park, Pa. Incorporated 1907. Opened to patients 1874. Executive officer, R. W. Walter, M. D. Number of beds, 200. Number of patients treated last year, about 500. Estimated value of hospital and grounds, \$200,000. Sources of income: From pay patients.

Florence Crittenden Home, 712 Sheridan Ave., Scranton. Incorporated 1897. Executive officer, F. M. Hannah, 446 Madison Ave., Scranton. Number of beds, 40. Number of patients treated last year, 70 inmates. Estimated value of hospital and grounds, \$18,000. Sources of income: Charity.

Pittsburgh Sunshine Children's Home, 3532 California Ave., Pittsburgh. Incorporated 1907. Opened to patients 1906. Executive officer, Mrs. W. H. L. Newingham, Pres. Number of beds, 48. Number of children treated last year, 81. Died, 1. Estimated value of hospital and grounds, \$16,000. Sources of income: Contributions, State aid.



West Philadelphia General Homœopathic Hospital, 1234 North 54th St. Incorporated December 19th, 1904. Opened to patients March, 1905. Secretary, John S. Wilson. Number of beds, 40. Number of patients treated last year, 720. Died, 58. Estimated value of hospital and grounds, \$35,934.40. Sources of income: Donations, board of patients, State appropriation.

J. Lewis Crozer Home for Incurables and Homœopathic Hospital, Upland, Pa. Incorporated 1898. Opened to patients 1900. Executive officer, S. K. Ubil, Sup't. Number of beds, 80. Sources of income: Endowment, private.

Homœopathic Medical and Surgical Hospital, Reading. Incorporated 1890. Opened to patients 1891. Executive officer, L. A. Shollenberger, M. D., Supt. Number of beds, 75. Number of patients treated last year, 1,172. Died, 47. Estimated value of hospital and grounds, \$75,000. Sources of income: State aid, private patients and contributions.

Homœopathic State Hospital for the Insane, Allentown. Not yet opened for patients. Harry C. Trexler, President, Board of Trustees. Henry I. Klopp, M. D., Superintendent, Allentown. Capacity, 1,000. Estimated value of hospital and grounds, \$2,058,000. Supported by State appropriation.

#### DISPENSARIES.

Women's Southern Homœopathic Dispensary, 739 S. Broad St., Philadelphia. Incorporated 1896. Opened to patients 1896. Secretary, Annie M. Miller, 1911 Mt. Vernon St., Philadelphia. Patients treated last year, 991. Prescriptions given last year, 2,454. Visits made to patients outside, 1,171.

Women's Homœopathic Association of Pennsylvania, 20th St., Susquehanna Ave. and Dauphin St. Incorporated 1882. Opened to patients 1883. Secretary, Mrs. F. B. Skinner, Philadelphia Bank Bldg., Philadelphia. New patients treated last year, 3,531. Patients treated last year, 12,982. Prescriptions given last year, 12,925.

St. Luke's Homœopathic Dispensary, 15th and Wingohocking Sts., Philadelphia. Incorporated March 9, 1896. Opened to patients June 9, 1896. Secretary, Miss Mary E. Lewers, 81 Fischer's Lane, Philadelphia. New patients treated last year, 1,712. Patients treated last year, 7,694. Prescriptions given last year, 6,715.

Children's Homœopathic Hospital Dispensary, Philadelphia. Incorporated 1877. Opened to patients 1877. Secretary, Walter Strong, M. D., 2105 N. 13th St., Philadelphia. New patients treated last year, 7,583. Patients treated last year,

11,583. Prescriptions given last year, 8,161. Visits made to patients outside, 342.

The Homœopathic Medical and Surgical Dispensary, Pittsburgh, Pa. Incorporated 1866. Opened to patients 1866. Secretary, Geo. L. McCoy, 5514 Baum St., Pittsburgh. New patients treated last year, 4,500. Patients treated last year, 13,527.

Hahnemann Hospital, Philadelphia. Incorporated 1848. Opened to patients 1848. O. R. Edwards, Supt., Philadelphia. New patients treated last year, 11,744. Patients treated last year, 62,414. Prescriptions given last year, 20,691.

Dispensary of the Homœopathic Medical and Surgical Hospital, Reading. Incorporated 1890. Opened to patients 1887. L. A. Schollenberger, Supt. Number of patients treated last year, 13,244.

West Philadelphia General Homœopathic Hospital and Dispensary, 1229 N. 54th St., Philadelphia. Incorporated December, 1904. Opened to patients 1904. Secretary, John S. Wilson, 101 S. Front St., Philadelphia. New patients treated last year, 4,806. Patients treated last year, 7,058.

#### REPORT OF COMMITTEE ON LEGISLATION.

Dr. John J. Tuller, chairman of the Committee on Legislation, presented the following report on behalf of this committee:

*Mr. President, and Members of the Homœopathic Medical Society of the State of Pennsylvania:*

The only object for the existence of this committee being to guard the legislative interests of the homœopathic medical profession and to take action where those interests are assailed, and there having been no meeting of the Legislature in this State since the last meeting of this Society the committee has of necessity been inactive and therefore has nothing to report of work done in the past year. Your committee desires, however, to sound the warning of coming dangers which may put it actively to work before the meeting of the next Legislature in January, 1913. A bill has already been drawn under the direction of the Pennsylvania Pharmaceutical Association that will establish new regulations in regard to the prescription, sale and dispensing of narcotic drugs which will have to be carefully studied. It also proposes to create a board which shall be empowered to employ agents to visit all places in this State where drugs of any kind or description are sold or dispensed. Whether these places be public or private such as physician's offices, and empowered to confiscate all drugs not prepared ac-

cording to directions laid down in the United States Pharmacopoea and the National Formula. An attempt will also be made to prohibit by legal enactment the dispensing of medicine by physicians except by means of written prescriptions through legalized druggists.

It requires but little consideration to realize what an effect all this will have on the medical profession and particularly on the homœopathic branch of the profession. To guard the work that has been done in the past and to protect the profession against injustice in the bills that are to come before the Legislature of 1913 is the work that rests before your committee during the coming year.

Respectfully submitted,

JOHN J. TULLER, *Chairman.*

#### REPORT OF COMMITTEE TO ENCOURAGE THE STUDY OF HOMOEOPATHY.

Dr. J. H. McClelland reported as follows on behalf of the Committee to Encourage the Study of Homœopathy:

In the brief report herewith presented it is only deemed necessary to bring to the attention of the Society certain almost self-evident propositions.

The first of these relates to the enlistment under our banner of young men with a predilection for medicine and who are qualified by education and personal character for the profession, and in order to do this it is absolutely necessary that we make a personal campaign to secure the right material among our clientele and friends. It will not do to simply encourage a young man to study medicine. We must endeavor to set forth the special value of our particular branch of the profession, and if we succeed in enlisting him, then to encourage an earnest *esprit de corps* which will make him an ardent advocate of our method of therapeutics. We must make him understand that homœopathy is not merely a matter of words and doctrines, but is a practical and successful system of therapeutics.

Secondly, we should forward the movement begun a short time ago to provide help for young men who are able and willing to enter the profession, but have not the means. The multiplication of alumni associations with this object in view is to be encouraged. It is true there are many calls on the profession, but if we aid each one of the worthy ones, we will not impoverish ourselves, and will hasten the time when our school will take its proper place in the medical world.



And thirdly: It becomes Pennsylvanians to foster their own institutions, hospital and colleges, and with this end in view we should direct every student we can influence to our own Hahnemann College of Philadelphia.

These are the self-evident propositions which I would respectfully submit for the consideration of this Society.

J. H. McCLELLAND, *Chairman.*

#### REPORT OF COMMITTEE FOR COMBATING THE SOCIAL EVIL.

Dr. E. T. Schreiner presented the following report on behalf of the Committee for Combating the Social Evil:

Your Committee for combating Social Evil reports great activity in the application of one method, viz.: The overcoming of Social Evil with Social Good. The increase of public playgrounds under trained supervision, churches and school houses open for social recreation and instruction in recreation, as well as other branches of knowledge, are all combating social evil. Instruction in sex physiology and hygiene is being introduced in the schools. The lack of qualified teachers in the higher grades being the chief drawback. At the last meeting of the A. I. H. a physician high in authority advocated segregation with governmental control and quarantine of the infected prostitute, but not of the man who contracts her disease.

Your committee believes that both should be equally safeguarded. The same authority claims that our daughters might not safely walk our streets if all prostitutes were eliminated.

Your committee holds that our daughters can be much more economically safeguarded than by fostering prostitution. For general instruction your committee recommends a recent book by Miss Jane Addams, entitled "A New Conscience and an Ancient Evil."

Respectfully submitted,

E. T. SCHREINER, M. D., *Chairman.*

#### REPORT OF THE NEUROLOGIST.

*Mr. President, and Members of the State Society of Pennsylvania:*

Your neurologist would report the year to have passed and dealt out to us a more kindly hand than in former years as to the number of deaths reported.

The occasion then is one for the equipment of younger men to fill the vacancies which we all know must come and the preparation for the great work that these men have begun, for it is

a laurel won to have one's chief ambition taken up and followed out by those prepared and made by a proper reading and understanding of the works of Providence.

I would offer to you for permanent record the following:

Doctor Charles B. Wurtz.

Gustav A. Mueller.

William H. Senderling.

William H. Malin.

John Black McClelland.

C. P. Seip.

DR. CHAS. B. WURTZ.

Dr. Chas. B. Wurtz, 2341 North Fifth street, Philadelphia, died suddenly at his home on February 12, 1912.

Dr. Wurtz was born in Bridesburg fifty-two years ago. He was graduated from the Central High School, after which he entered the Hahnemann Medical College, from which he was graduated in 1880.

Dr. Wurtz was a member of the Carl Vischer Medical and Surgical Society, and the Germantown Medical Society, the Philadelphia County Homœopathic Medical Society and the State Homœopathic Medical Society, and other organizations.

DR. GUSTAV ADOLPH MUELLER.

Dr. Gustav Adolph Mueller, 49 years old, a member of the State Board of Medical Examiners, and a noted throat and nose specialist, died in the Homœopathic Hospital, Pittsburgh. Dr. Mueller was born in Crestline, O., a son of August Mueller. He came to Pittsburg when a boy and attended the Sharpsburg Academy and later the university of Michigan. He graduated from the Hahnemann Medical College in 1885 and went to old Allegheny. Dr. Mueller established a large practice and was made city physician of Allegheny. He retained that position until 1894, when he went abroad and took up post-graduate work. He studied diseases of the throat and nose at Munich, Vienna, Paris, London and Berlin. Returning to Pittsburg he established an office in Penn avenue, and practiced as a specialist. He was active in the management of the Homœopathic Hospital and was a member of the Executive Committee and Board of Trustees and of the Medical Board of his department of the Homœopathic Hospital. Dr. Mueller served four terms as a member of the State Board of Medical Examiners, and was recently appointed by Governor Tener for a fifth term. He was a member of the American In-

stitute of Homœopathic Society of Pennsylvania and the Homœopathic Medical Society of Allegheny County. He was formerly president of the latter society. He was also a member of the faculty of the Pittsburgh Training School for Nurses, and a member of the American Homœopathy and Laryngological Society, the East End Doctors' Club, the University and Duquesne Clubs of the city, the Oakmont Country Club, the Sportsmen's Association of Cheat Mountain and the Alumni Association of Hahnemann College. He was also a Mason and had filled all the offices in the local lodge of the Odd Fellows and was a representative to the Grand Lodge. He was also medical director of the Odd Fellows' Endowment Association. Dr. Mueller was one of the incorporators of the Bank of Secured Savings of Allegheny. In 1891 he married Miss Grace Miller, of the Northside, who died in 1896. In 1900 he married Miss Nell S. Anderson, of Steubenville, O. His widow, two sons, Gustave A., Jr., and Robert, and five sisters, Mrs. Annie Muller and Miss Clara Mueller, of Northside; Mrs. Moses Calhoun, of Monongahela, etc., remain.

The funeral will take place Monday afternoon. Services will be conducted at Trinity church, Sixth avenue, at 2.30 o'clock. Interment later in Highwood Cemetery

DR. WILLIAM H. SENDERLING.

Dr. William H. Senderling died at his home, 1934 North Sixth street, Philadelphia.

Dr. Senderling was born in this city on June 12, 1847, and was graduated from the Jefferson Medical College. The first six years of his professional life were spent in Port Carbon, Pa., in the reign of the "Molly Maguires." He achieved the reputation for courage in responding quickly and promptly to calls for aid, and although he traveled on horseback to all parts of the coal region by day and night, he was never molested by the "Mollies."

In 1876 he came back to this city. He was an active member of the Germantown Medical Society, the Carl V. Vischer Medical and Surgical Society, and the staff of St. Luke's Hospital. He was also prominent in lodge circles, being a member of St. Paul Lodge No. 481 F. and A. M., Palestine R. A. Chapter No. 240; St. John's Commandery No. 4, Knights Templar, of Philadelphia, Consistory and Lu Lu Temple.

A widow and one daughter survive.

DR. WILLIAM H. MALIN.

Dr. William H. Malin, of 8400 Germantown avenue, Phila-



delphia, Pa., died at his home on Monday, October 16, 1911, after a rather long illness.

Dr. Malin was born at Trenton, N. J., and started the study of Medicine at the Hahnemann Medical College of Philadelphia, Pa., locating for practice in Germantown where he had since resided. He was the organizer of the Hahnemann Medical Club of Philadelphia, a member of the County, and State societies, also Germantown Medical Club and the American Institute of Homœopathy.

He was affectionately called the "George Washington of Germantown." Dr. Malin will be sadly missed by the members of the profession.

#### DR. JOHN BLACK MCCLELLAND.

Dr. McClelland was one of the oldest and best known of our Society. After a long illness he died at his home in Pittsburgh, Pa., on August 4, 1912.

Dr. McClelland was born in Pittsburgh and was the grandson of the Rev. Dr. John Black, one of the pioneer ministers of Pittsburgh.

He was a member of the G. A. R., and of the Union Veteran Legion. He served in the Union Army during the entire Civil War.

He was educated in the Hahnemann Medical College of Philadelphia, Pa., graduating with the class of '79, and began practice in Pittsburgh immediately afterward.

For the last thirty-two years Dr. McClelland had been connected with the Homœopathic Hospital.

He was a member of the Third Presbyterian church, of the Pittsburgh and University Clubs, and of various medical societies.

He leaves two brothers, Dr. J. H. and Dr. R. W. McClelland.

#### DR. C. P. SEIP.

Atlantic City, Aug. 6, 1912.—In a rolling chair on the Boardwalk with his wife by his side Dr. C. P. Seip, of Pittsburgh, a member of the State Examining Board and last appointed, died to-night.

He had come here for the regular session of the Pennsylvania Board, which began Monday at Haddon Hall.

All day to-day Dr. Seip had been working away in his shirt sleeves with the other members poring over papers from the various examinations. As far as colleagues could observe, he was as fit for duty as any of them.

To-night rather late he and his wife took a rolling chair and started down the Boardwalk.

Before Young's Pier had been reached Dr. Seip caught his wife's hand and said:

"I'm going, I'm going."

The diagnosis was correct for in a few moments he was gone. It was a typical case of heart disease, so determined by the other doctors of the Board.

Dr. Seip was one of the foremost physicians in Western Pennsylvania. He had reached the age of sixty-five. He has a son practicing medicine in Pittsburgh, but his daughters at this time are all abroad.

The vacancy to which Dr. Seip was named by Governor Tener six months ago was due to the death of the other appointee, who lived three months only after appointment.

Dr. Seip was born near Craften sixty-five years ago and was of a family that was among the oldest in Western Pennsylvania.

He served four years in the Union Army during the Civil War, being a member of Company B of the Fourth Pennsylvania Cavalry.

Just after the war he studied medicine with Dr. H. H. Hoffman in Pittsburgh, and in 1868 graduated from the Hahnemann Hospital in Philadelphia, and practiced from 1870 until 1871 in Canton, O.

Since that time Dr. Seip has practiced in Pittsburgh, and he has been one of the leading surgeons of the State.

He was a member of the State Board of Education and License, which examines applicants for homœopathic certificates, and it was while attending the annual meeting of the Board that he was taken ill. Really, though, he had been in ill health for several months, and no diagnosis had been made of his case.

Dr. Seip was a Mason, a member of the G. A. R., the Union Veteran Legion, and the Evangelical Protestant church at Sixth avenue and Smithfield street.

He was a member of the East End Doctors' Club, the Pennsylvania State Medical Society and the Allegheny County Medical Society, the American Institute of Homœopathy and was on the surgical staff of the Homœopathic Hospital.

He was one of the founders of the Soldiers' Civic League of Allegheny county and one of the first commanders.

Four children survive. Two, Adela M. and Helen, are in Europe and last night could not be located. Two weeks ago they left Pittsburgh and landed in London only last Saturday.

There is no possibility that they can be in Pittsburgh for the funeral.

The two other children are Mrs. W. E. Berger, of Ashland, Ky., and Dr. Herman H. Seip, of Pittsburgh.

Dr. Seip also leaves his widow and a brother, Philip Seip, of Homer street.

#### AMENDMENTS.

The following amendments proposed at the meeting of the Society at Bedford Springs, September, 1911, were acted upon:

I. That in Article III, Section 2, where the word "Corresponding" precedes the word "Secretary," the word "Corresponding" be omitted.

On motion it was decided that the amendment be adopted as read.

II. Article IV, Section 1, be altered by the omission of the words "A corresponding secretary," and the omission of the word "Recording" before "Secretary" in second line.

On motion this amendment was carried.

III. Add to Section I.—"And an associate editor."

On motion this amendment was adopted.

IV. Add to Section 5,—"The Associate Editor shall be elected by the Board of Trustees to serve one year from January 1st of each year."

V. Article V, Section 3, be altered by striking out the word "Recording" on first line.

This amendment was adopted.

VI. Article V, Section 4, be altered by striking out the word "Corresponding" on line one and inserting the word "Further" between the words "shall" and "preserve" on line one; substituting the word "member" for "ex-officio chairman" in last line of said section.

This amendment was adopted.

VII. Article V, add Section 9: "The Associate Editor shall, in conjunction with the Publication Committee, have charge of publishing in the *HAHNEMANNIAN MONTHLY* the transactions and other matters concerning the Society, subject to the contract between the Society and the *HAHNEMANNIAN MONTHLY*."

On motion the amendment was carried.

VIII. Article VII, Section 2, be altered by striking out the word "Corresponding" before the word "Secretary" in fifth line of said section.

On motion the amendment was carried.



IX. Article VIII, Section 4, be amended by striking out the word "Corresponding" before the word "Secretary" in the last line of said section.

On motion the amendment was carried.

X. In Article IX, wherever the words "Corresponding Secretary" occurs, such words shall be stricken out and wherever the word "Recording" precedes the word "Secretary" the word "Recording" shall be omitted.

On motion the amendment was adopted.

XI. Article IX, Paragraph 4. Strike out the entire paragraph and insert "A Publication Committee," consisting of three members, one of whom shall be the secretary, two to be appointed by the President.

It shall be the duty of the committee to have published in the *HAHNEMANNIAN MONTHLY* all of the transactions of the Society (comprising the business transacted at its meetings, a list of its officers and committees, the papers read and the discussions upon them), and such other matters as may be deemed advisable for the advancement of the interests of the Society, subject to the contract between the Society and the *HAHNEMANNIAN MONTHLY*. All transactions and other matters presented at an annual meeting shall be published within one year or prior to the next following annual meeting.

On motion the amendment was adopted.

XII. Article XI to be altered by striking out the word "Corresponding" preceding the word "Secretary."

On motion the amendment was adopted.

The Board of Censors then reported favorably on the name of Dr. Williamson, of Warren, Pa.

On motion Dr. Williamson was elected a member of the Society.

#### SEPTEMBER EIGHTEENTH.

The meeting was called to order by the President, Dr. Palen.

The following amendments to the By-Laws were then presented: (I) To change word "five" in Article VII, Section 1, to "two." (II) To omit "Gynecology," third line, and "obstetrics," sixth line, Article VIII, Section 1. To insert after "surgery," "gynecology and obstetrics," eleventh line.

Dr. Ralph Bernstein presented a resolution of protest against the removal of Dr. Wiley as Chief Chemist of the United States Pure Food Commission, and of Harry P. Cassidy, as

special agent of the Pure Food Commission. This motion was duly seconded and carried.

The following officers were elected for the coming year :

President, Dr. H. S. Nicholson, Pittsburgh.

First Vice-President, Dr. M. M. Fleagle, Hanover, Pa.

Second Vice-President, Dr. J. H. Heimbach, Kane, Pa.

Secretary, Dr. E. H. Pond, Pittsburgh, Pa.

Treasurer, Dr. Ella D. Goff, Pittsburgh, Pa.

Necrologist, Dr. W. F. Baker, Philadelphia.

Censor, Dr. R. T. White.

Trustees—Dr. Wm. M. Hillegas, Philadelphia; Dr. T. M. Johnston, Pittston, Pa.; Dr. W. G. Deitz, Hazleton, Pa.

State Society Editor, HAHNEMANNIAN MONTHLY, Dr. Gilbert J. Palen.

The following members were appointed by the President to serve as a Publication Committee: Dr. E. H. Pond, ex-officio; Dr. Ralph Bernstein, Dr. H. S. Weaver.

#### SEPTEMBER NINETEENTH.

Thursday morning, September 19th, the meeting was called to order by the President, Dr. Gilbert J. Palen, when the name of Dr. Frank Barthmaier, of Philadelphia, was proposed for membership. On motion Dr. Barthmaier was elected member of the Society.

The report of the Committee on President's Address was then presented:

We fully endorse the President's suggestion relative to enabling medical graduates to seek such locations as they are best fitted to fill. We would suggest that a permanent bureau be established to investigate suitable locations for prospective practitioners of homœopathic medicine. Usually, in every town some one person is the key to the situation. This Bureau, as far as possible, should ascertain suitable people to refer these prospective practitioners to, that they may from the first obtain such introduction as will enable them to be successful.

This Bureau should work in conjunction with a similar bureau to be established in our college; and we further suggest that the present occupant of the chair be made chairman of this committee, because of his familiarity with the work which has been already done in this connection by the State and various county medical societies.

Your committee heartily endorses the President's remarks

or resume of the work by the State Board of Medical Education and Licensure; and we feel that the Board, as far as we know, has been entirely satisfactory to our school. If the appointments on the Board are made in the future as wisely as in the past, the standards of medical education in Pennsylvania will be the standards for many other States.

We heartily endorse the President's suggestion that our college should be endowed, and to this end we suggest that a bureau be established to work in conjunction with the Ladies' Auxiliary to the end that we may later have for our college an endowment of at least a million dollars.

Your committee further endorses the report with reference to the establishment of an homœopathic literature and begs leave to suggest that the President be empowered to appoint a committee which shall wait upon the Dean of the Hahnemann Medical College of Philadelphia with this object in view; the importance of this to be thoroughly impressed upon the committee and the faculty of Hahnemann Medical College through its governing faculty. It is the consensus of opinion of your committee that this could be more quickly accomplished through our State teaching institution, the Hahnemann Medical College at Philadelphia.

Your committee feels that the subjects touched upon in the President's address are ones of vital importance to this Society, and to the profession at large, and would urge upon the Society immediate action in these matters.

Respectfully submitted,

COMMITTEE TO CONSIDER THE PRESIDENT'S ADDRESS,

WM. ALVAH STEWART, *Chairman.*

#### MEMBERS ELECTED.

The following physicians were duly elected to membership during the sessions of the Society:

Geo. W. Ramsey, M. D., 1732 Regina street, Harrisburg, Pa.; W. W. Preston, M. D., Montrose, Pa.; E. B. Rossiter, M. D., 343 High street, Pottstown, Pa.; C. Dudley Saul, M. D., 1825 Chestnut street, Philadelphia; Frank Barthmaier, M. D., Philadelphia; Annie Marie Smith, M. D., 130 W. Market street, Lewistown, Pa.; S. M. Rinehart, M. D., Jenkins Arcade Bldg., Pittsburgh; Joseph W. Allen, M. D., 455 W. Main street, Monongahela, Pa.; J. C. Hornecker, M. D., Forbes and Atwood street, Pittsburgh; W. L. Hamilton, M. D., Channing avenue, Malvern, Pa.; Henry Irwin Klopp, M. D., Homœopathic State Hospital, Allentown, Pa.; R. O. Diehl, M. D., Manheim, Pa.; Edward A. Pitcairn, M. D., Homœo-



pathic Hospital, Pittsburgh; H. T. Moyer, M. D., 1 E. Main street, Lansdale, Pa.; A. J. Craig, M. D., Fort Washington, Pa.; Wm. J. Best, M. D., 4807 Lancaster avenue, Philadelphia; Donald Macfarlan, M. D., 1805 Chestnut street, Philadelphia; Geo. H. Williamson, M. D., Warren, Pa.; W. Hayes Brown, M. D., 6607 Lansdowne avenue, Philadelphia; Samuel Henry Pettler, M. D., Children's Homœopathic Hospital, Philadelphia; E. Victor Leight, M. D., Annville, Pa.; Wm. J. Lynch, M. D., Frazier and Master streets, Philadelphia.

The Auditing Committee report that they had examined the books of the Treasurer and found them to be correct.

Upon motion the report of the committee was accepted.

Dr. Stewart then took the chair and expressed thanks to the Society and to the President, Dr. Gilbert J. Palen, for his able and efficient work in behalf of the Society.

The session then adjourned to meet at such time and place as should be selected by the Board of Trustees in 1913.

### AN IMPORTANT COMMUNICATION.

Are you a member of the State Society? If not, send in your application at once. The organization needs you, and you also need the benefits which association with the members can give you. Every homœopathic physician practicing in this State owes it to himself to become affiliated with this organization.

We have the biggest and best and most influential State organization in the country, and we can only maintain this position by continuing the good work of previous years.

To you who are members, let me urge you to become interested in your nearest neighbor who is not a member and endeavor to get him into line.

A membership blank will be found in this copy of the HAHNEMANNIAN. Make good use of it by sending in your application at once. Do not delay, as the next State meeting will be held September 2, 3, 4, at Bedford Springs.

CHAS. A. LEY,  
Chairman of Membership Committee,  
First National Bank Building,  
Pittsburgh, Pa.

## EDITORIAL

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### ORAL SEPSIS AS A CAUSE OF ILL HEALTH.

WHILE many physicians recognize in a vague way the fact that septic infections of the teeth and gum are capable of producing systemic disturbances, there are probably few who appreciate fully the very common occurrence of such conditions and the serious disturbances of health that frequently result from them.

Of the many states of ill health that may result from the absorption of the toxic products of oral origin, the most common are various types of gastric disorders, anæmia, which may be profound enough to simulate pernicious anæmia, acute and chronic arthritic inflammations and various forms of localized suppurative processes which may occur in distant parts of the body.

Perhaps the first authority to emphasize the importance of oral sepsis in the production of systemic disease, was Dr. William Hunter. He originated the term "Oral Sepsis." According to his conception, this term covered not only pyorrhœa alveolaris, but of every other form of trouble, dental and oral, producible by septic infection in the mouth. The term, therefore, covers in addition to pyorrhœa alveolaris, stomatitis, gingivitis, dental caries and alveolar abscess.

Mills, in a recent article in the *British Medical Journal*, has reported a series of eighty cases occurring in private practice during the past four years in which the pathological conditions present entirely disappeared after proper attention had been given to the teeth.

Thirty-six of these cases consulted him because of want of appetite, dyspepsia and anæmia. This symptom complex is a very characteristic one. It is probably the most common group of symptoms found in connection with oral sepsis.

Another interesting group that came under Mills' observation consisted of fifteen women suffering from various forms of menstrual and nervous phenomena associated with the climaxis. It is remarkable to note that they all improved promptly when proper attention had been given to the mouth, although general constitutional treatment had failed to produce beneficial results.

Nine cases of pyogenic infection in distant parts of the body were found to have their origin in the mouth. Among those may be mentioned, carbuncle, septic infection of the hand, general furunculosis and anal abscess.

The arthritic cases, of which there were ten in Mills' series, varied in type. The majority simulated very closely arthritis deformans, while some were more active in type, simulating acute infective arthritis.

In order to secure satisfactory therapeutic results in constitutional disorders of oral origin, the important factor is to recognize the mouth as a source of the trouble. After that the management of the case is comparatively simple.

Badly decayed teeth should be removed, while those that are only partially diseased should be cleaned and filled by the dentist.

A thorough mechanical cleansing of the teeth, especially at the junction of the gums should next be carried out. In this connection we must emphasize the fact that *thoroughness* is the essential point in this process, and unless the physician gives specific instructions, the work is not likely to be done as satisfactorily as we would desire. After the decayed teeth have been extracted or properly filled and the mechanical cleansing has been carried out, the patient should be instructed in the proper cleansing of the teeth and mouth by means of a tooth brush with a suitable antiseptic powder or paste, and he should be directed to use the tooth brush two or three times a day as conditions seem to warrant. Following the cleansing with the tooth brush, the mouth should be washed at least once daily with a dilute solution of peroxide of hydrogen.

We believe that if such a thorough cleansing of the mouth were carried out systematically the number of patients suffering from disorders of the stomach would be materially diminished and many cases of chronic anæmia and of chronic arthritis would be satisfactorily cleared up.

G. H. W.



**NEW MEMBERS FOR THE STATE SOCIETY.**

IN the present issue of the *HAHNEMANNIAN MONTHLY* will be found a communication from Dr. Charles A. Ley, Chairman of the Membership Committee of the Homœopathic Medical Society of the State of Pennsylvania, urging every member of the Society to "get busy" among the homœopathic physicians in his neighborhood and ask them to forward their applications for membership in the Society before the coming meeting, to be held at Bedford Springs, in September.

This appeal is one that should be earnestly heeded by every homœopathic physician in Pennsylvania who has the interest of the profession at heart. As much as the State Society needs new members, individual practitioners of homœopathy need the State Society even more, and every member should consider himself a committee of one to bring this matter to the attention of the first homœopathic physician he meets and convince him that he owes it to himself and to the profession to forward his application at once.

The State Society is an organization of which every homœopathic practitioner of Pennsylvania may well be proud. The work it has done to advance the interest of homœopathy, both from a scientific and legislative standpoint, cannot be overestimated, and in order to maintain its usefulness and efficiency it must be a growing organization. After you have gotten a new member, your next duty is to bring him along with you to meet his fellow physicians at Bedford Springs, September 2, 3, 4, 1913.

G. H. W.

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**FRIEDMANN'S TUBERCULOSIS SERUM CONDEMNED BY THE NEW YORK BOARD OF HEALTH.**

AT a recent meeting of the Board of Health of New York City, it was unanimously voted that the use of living cultures of bacteria in the inoculation of human beings, for the prevention or treatment of diseases, should be prohibited until full and complete data regarding the methods of use, including a specimen of the culture and other agents employed therewith, be presented to and examined by the Board. This resolution was passed because of the fact that many of the patients injected by

Dr. Friedmann with his tuberculin serum, are reported to have been seriously injured by the treatment employed and it is supposed to have caused death in several instances. As a result of this resolution the Friedmann Institute is expected to close its doors at an early date. In the meantime, Friedmann has escaped to Europe with a large roll of American money and sufficient material to form the basis of a rather extensive book on the gullability of the American public. G. H. W.

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**TYPHOID FEVER.**—In a recent issue of the *New York Medical Journal*, Wm. N. Johnson and Charles C. Watt, Jr., of Germantown, have contributed an excellent article on "Typhoid Fever; Its Milk Free Treatment." It is a study of sixty-five cases at the Germantown Hospital.

The dietetic treatment, on which the greatest reliance was placed for the results obtained, and which in their opinion was responsible for the very low percentage of diarrhea, distention, hemorrhages, and no perforations, consisted of broths, soups, gruels, gelatin, eggs, sugar of milk, and butter. Milk was absolutely eliminated, except in the convalescent stage. Great reliance was placed on gelatin, which was given almost *ad libitum*. According to Kemp, the ingestion of 7.5 per cent. of the total heat requirement of the organism in the form of gelatin spares twenty-three per cent. of the body's proteid. There is a total of 2,800 calories required by a man of 154 pounds weight (Chittenden); 210 calories in gelatin are necessary (one gramme of gelatin contains 4.1 calories), so about fifty grammes of gelatin, or about 1.5 ounce, are necessary. This amount in one quart of water gives a five per cent. solution, and can be flavored with lemon, vanilla, orange, or sherry and sweetened with sugar of milk, and be given in divided doses during the day—between other feedings. Gelatin lessens the tendency to hemorrhage, in Johnson and Watt's opinion, and was largely accountable for the freedom in these cases from this serious complication.

If venous thrombosis occurs, gelatin should be stopped. The gruels (barley, rice, and oatmeal) may be made of different consistence. It is well to begin with a thin gruel (strained) and note the effect, and gradually thicken it if well borne.

For barley gruel, thin, they use one tablespoonful of Robinson's barley flour to one pint of water; boil three quarters of an hour; for thick gruel they use two tablespoonfuls of the flour. For rice and oatmeal gruel, they use the same proportions as for the barley. Strain all. For adults, there is added to the gruels the yolks of four eggs, which contain considerable fat, and four drachms of sugar of milk. For children they use two yolks of eggs and half the quantity of sugar of milk. A pat of butter may be added to the gruel.

## GLEANINGS

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DESICCATION AS A THERAPEUTIC MEASURE.—By Robert L. Pitfield.—Perhaps one of the oldest antibacterial measures known in the arts of man is desiccation. All are familiar with desiccated foods, such as fruits, fish, meat, etc. Drying deer and fish flesh as a means of preserving was known to the Indians probably before the earliest medical book was written.

In medicine various methods have been employed to hasten desiccation as a means of promoting healing. A leg or arm dry, dead, and of course gangrenous, is a comparatively harmless member compared to a moist gangrenous limb. Desiccation may be said to be a very powerful agent in effecting spontaneous amputation of a dead extremity, and is therefore a valuable conservative curative agency.

Physicians have for a long time endeavored to encourage desiccation; witness the old method of adding lint to an ulcer to encourage scabbing or drying. Drying probably does more toward limiting the spread of contagion than any other agent save oxygen and light. Pasteur found that the virulence of a spinal cord for a case of rabies became rapidly attenuated if hung to dry in a desiccating chamber. The bacteria that most quickly yield to the mildest germicidal chemicals also succumb quickest to the effects of drying. Bacteria live best in moist or hygienic media. The cholera vibrio and the typhoid bacillus die quickest because of a thin enveloping membrane, while spores and tubercle bacilli, because of tough, impervious coats, die hardest when exposed to chemicals and the effects of drying. Dust often harbors anthrax spores and tubercles and tetanus bacilli for years.

Quite a school of surgery has developed about the dry treatment of wounds. Good surgeons will never wash a clean uninfected incision when dressing it, not even moistening the gauze to loosen it from the wound. Burns are best treated by dry methods, as the history of the two cases narrated below will show, and as it has been shown by numerous observers. This case is of interest:

Baby D., aged eleven months, in very hot July weather was scalded badly. The whole back was one huge bleb from the neck to waist. He was much shocked and suffered greatly. By keeping his back clean and perfectly dry and exposed at all times to the air, and with the aid of plain stearate of zinc and a single layer of gauze, the bleb at the end of twenty-four hours began to dry up; in forty-eight hours desiccation was almost complete. At the end of ten days the back was clean of all blebs and most of the scabs, save in one fold of the skin above the nates which was frequently wet with urine. This became slightly infected and ulcerated, but finally healed under dry treatment. The only scarring occurred in this area, which was about as big as one's



thumb. Morphine was used to allay pain and encourage quiet, so that the drying treatment could be carried out.

Baby M., aged two years, in August pulled a pot of boiling syrup over his arms and chest. Morphine, stearate of zinc, and gauze were used. Drying was encouraged in every way, with the result that a large scald about ten inches square quickly yielded to treatment.—*Therapeutic Gazette*.

CONDITIONS DURING PREGNANCY WHICH JUSTIFY ABORTION.—Humpstone writing in the *Long Island Medical Journal* for January, 1913, tells us the indications for therapeutic abortion are undergoing a revision these days in the light of the advances of the pathology of pregnancy. Alas, in the morally weak minds of many of the profession this revision has come to include sociologic and economic indications which are contrary to the laws of nature and the state, and contrary to the best interests of the home, the nation, and civilization!

Therapeutic abortion is the induction of abortion by a physician to save the life of the mother, and is only to be accomplished after consultation has carefully considered the dangers and determined its necessity. Conservative as we should be in meeting this problem, it is not to be forgotten that we may be too conservative, and wait too long, until abortion will not save our patient, and this applies particularly to pathological conditions which are directly due to pregnancy.

These are some of the more serious manifestations of the toxemia of pregnancy, the exact cause of which we do not know but now fully believe to be either some toxin obtained from the fetal or placental metabolism, or else some disturbance of the maternal metabolism, most probably in the ductless glands, which makes the maternal excretion of the normal fetal products of metabolism impossible. This toxin has a most marked effect on the liver, on the entire nervous system, the kidneys, the heart, and the blood-vessels—these pathological effects being manifest clinically by persistent vomiting, continued high blood pressure, loss of flesh, muscular weakness, various psychoses, diminished urine with its disturbed protein excretion. Any one of these symptoms may demand abortion.

Persistent vomiting, when associated with a pulse rising to 100 or over and a little fever, and rapid loss of flesh, is an absolute indication for abortion, and it is to be remembered that it is very easy to make the mistake of carrying these patients too far before relieving them. If the vomiting does not cease after ten days of suitable treatment and the pulse is 100 or over, no time is to be lost. These cases are to be carefully differentiated from the malingering hysterical cases of vomiting.

Continued high blood pressure, over 150, if associated with dyspnea and renal insufficiency and not responding in a few days to suitable treatment, is another absolute indication.

Muscular weakness increasing with the associated pains of a developing multiple neuritis, especially if there is present any psychosis, is an absolute indication; on the other hand, any increasing psychosis, even though there be absent any signs of the involvement of peripheral nerves, is an indication.

Last of these toxic cases is the rare type of nerve affection, chorea gravidarum, which is an absolute indication.

Besides the toxic causes, we have two other causes directly attributable to the pregnancy itself which demand immediate abortion—the one, an incarcerated retrodisplaced pregnant uterus, caught beneath the sacrum, which cannot be reduced under anesthesia; the other, an acute hydramnios in the early months of pregnancy, with its associated cardiac insufficiency.

The second class of cases demanding immediate abortion are those in which exists some disease which would be aggravated to the point of endangering life if pregnancy continued, and in which we may hope to considerably prolong life by ending pregnancy. We include in this class heart disease, kidney disease, tuberculosis.

Heart disease complicating pregnancy always presents a problem demanding the closest of observation and the keenest of judgment. Views on this question vary, from abortion of every case of heart disease to the opposite opinion that abortion is never indicated in heart disease. In dealing with this question we have always to consider not only whether it is possible to carry pregnancy to viability, but also how much invalidism and shortening of life will be caused by allowing this pregnancy to continue. It is undoubtedly a fact that life will be more or less shortened by pregnancy occurring in a patient suffering from endocarditis. The patient and her husband are entitled to an opinion in this matter. Two valvular lesions are, in Humpstone's opinion, absolutely indicative of abortion—the one, aortic stenosis; the other, mitral stenosis with or without insufficiency.

In cases with simple insufficiency of the valves, the most favorable are mitral insufficiency, when compensative hypertrophy is sufficient. These cases regularly do well. The important point to remember is, has this heart compensation been broken without pregnancy, and how many times, and how badly? If the compensation has been sufficient for ordinary health, pregnancy may be tried with the understanding that should a break in compensation occur which is not easily controlled by proper medication and rest, the immediate termination of the pregnancy is indicated.

In chronic diffuse nephritis, with exudation of finely and coarsely granular casts, where chronic uremic symptoms have persisted, it is out of the question to expect such damaged kidneys to be sufficient for pregnancy. The same holds true for the chronic diffuse nephritis without exudation, with its associated arterial thickening, blood pressure, and weakened heart muscle.

These cases are to be sharply differentiated from cases which have had one or more attacks of acute nephritis with or without pregnancy; such cases demand the most careful of observations, but are not in themselves necessarily indicative of abortion.

Tuberculosis is very unfavorably influenced by pregnancy. In Humpstone's opinion, in any case in which active pulmonary tuberculosis is manifest early in pregnancy, abortion should be performed. In the so-called arrested cases without systemic symptoms it is, he believes, justifiable to allow pregnancy to continue unless there are evidences of the disease lighting up. In the advanced cases of tuberculosis it is well to re-

member that the emptying of the uterus is likely to be followed by a very rapid fatal termination of the malady.

The last condition for which therapeutic abortion is indicated is not an absolute one. He refers to a pelvis so contracted as to be an absolute indication for delivery by the abdominal route. He does not believe we are justified in saying to all such women that they must go to term and have a Cæsarian. Such a patient still has the right to choose between abortion and Cæsarian at term, but it is our duty to influence her, everything else being equal, to carry her child.—*Therapeutic Gazette*.

APPENDICITIS IN CHILDREN.—Mitchell (*British Journal of Children's Diseases*) mentions forty cases, in which the initial treatment varied greatly. All were subjected to surgical treatment finally. The ages varied between 14 months and 13 years, the average duration of the illness being five days. Nausea and vomiting were not prominent symptoms, though abdominal tenderness and rigidity were present in every case at some time of the illness. A definite previous attack occurred in six cases, though there was a history of stomach in a much larger proportion. Four main groups were noted: (1) In nine cases a large walled-off abscess impinged directly on the abdominal wall. There were three deaths, due, respectively, to septic peritonitis, intestinal obstruction, and exhaustion. Of the recoveries five needed further operation for the removal of the appendix or cure of a ventral hernia. (2) Five cases showed localized abscess, only reached after opening the peritoneal cavity. One death occurred seven days after a second operation for subphrenic abscess. (3) Eighteen cases showed a spreading diffuse peritonitis, with gangrenous appendix in all but one case. Six deaths occurred—three within twenty-four hours of operation. Operation for ventral hernia was needed in several of the recoveries. (4) Eight cases showed a gangrenous appendix without peritonitis. There were no deaths, and in these the average duration of illness before operation was under twenty-four hours. In all, there were 40 cases, with 10 deaths, a mortality of 25 per cent., while in all cases operated on during the acute stage before infection had visibly extended beyond the appendix and its peritoneum, the mortality was nil. A simple enema was given before operation, salines with glucose and bicarbonate of soda continuously every two or three hours for twenty-four hours after. The affected area was well packed off, free pus mopped away, the appendix removed, and drainage employed in all but one case. He concludes that appendicitis in children is a dangerous condition, and deceptive because the stage of the disease is hard to determine. Cases in the catarrhal stage often recover without operation, but after a certain point the disease advances rapidly and often kills. Localized abscess is very dangerous in infants especially. Children are bad subjects for acute septic peritoneal infections, owing to the high position of the appendix in the abdomen; peritonitis is often diffuse from the first. Early diagnosis is everything.—*Charlotte Medical Journal*.

JACKING UP THE MEDICAL SCHOOLS.—The recent ninth annual conference of the Council on Medical Education of the American Medical Association led to important steps which should materially affect medical training in the United States. In 1904 there were 166 medical schools in



this country, while now there are about 100. In 1900 one medical school required for admission any education above a high school course. Now 60 schools exact a high preliminary requirement.

The next step under consideration by the Council is making compulsory an internship in a hospital, following graduation from a medical school. It is found that from the 70 better medical schools in the country there were 956 graduates last year, and of these about 70 per cent. received appointments as internes in hospitals. It was found by the Council that, of the 100 schools in the country, 25 or 30 are now refused recognition by the State Boards of their communities; and it is believed by Dr. Bevan, chairman of the Council, that the majority of these thirty schools will discontinue by merger or otherwise. The decrease which in the past eight years has come about in the number of medical schools, has been occasioned largely through merger of several small schools into one. In Louisville, for instance, five medical colleges were consolidated. "This decrease in number," says Dr. N. P. Colwell, "has not been to the detriment of medical education, but has resulted in giving medical students better opportunities. It has brought about fewer, but better, medical schools."

It was also agreed, by resolution, that all schools in the Association of American Medical Colleges shall include, as an entrance requirement, at least a year of previous college work in physics, chemistry, animal biology, and a modern language. Thus the medical curriculum will be buttressed at both ends.—*Medical Review of Reviews.*

THE RELATIONSHIP OF SYPHILIS TO INTERNAL MEDICINE.—The relationship of syphilis to internal medicine is a subject almost without bounds, and it is therefore necessary to restrict what I have to say to a limited field, and, indeed, do little more than touch upon a few important topics. The great importance which syphilis bears to the etiology of many well defined chronic diseases that incapacitate our population in the prime or a little after the prime of life is rapidly becoming evident. Indeed, as we investigate this one disease—syphilis—its effects become little less than appalling. The two situations in which *spirochæta pallida* seems most often to persist and where it causes most trouble, late in the disease, are the cardio-vascular system and the nervous system. The whole group of nervous diseases dependent upon syphilis, I should like to discuss later and at some length. But first let us see how frequent is cardio-vascular syphilis of some of the other systems which come directly under the observation of the clinician.

Of the cardio-vascular diseases dependent upon syphilis, syphilitic aortitis stands out most prominently. This manifestation, which usually produces symptoms some ten or twenty years after the primary infection, forms the basis of three very serious conditions, namely, aneurysm, aortic insufficiency, and angina pectoris. It can now be shown definitely that syphilitic aortitis is the direct cause of from ninety to ninety-five per cent. of all aneurysms of the arch of the aorta, so that for practical purposes aneurysm of the arch means syphilis. The same disease is responsible for about seventy-five per cent. of the cases of aortic insufficiency in adults and anywhere from thirty to fifty per cent of the cases of angina

pectoris in young adults. Aneurysm and aortic insufficiency are common diseases, and though angina pectoris is less often seen, it is still by no means rare. To the involvement of the coronary arteries by syphilitic aortitis, we must ascribe, as well, a certain proportion of cases of myocarditis, and it has been estimated that excluding aneurysm and aortic insufficiency, about twenty-four per cent. of patients suffering from cardiovascular diseases give a positive Wassermann reaction. With generalized arteriosclerosis, however, the conditions are different, and in only a small proportion of cases, about twelve per cent., is a Wassermann reaction obtained. If, therefore, we are to prevent the development of the severe cardio-vascular affections, that as you know deal a fatal blow to so large a proportion of our population, we must direct our attention to two diseases of perhaps equal importance, syphilis and rheumatic fever. Were we to eradicate these two infections, chronic disease of the heart and aorta would, for the time of superannuation, be a rarity.

Of the general diseases next in importance, we must perhaps mention the bone and joint manifestations of syphilis. It can now be shown that many of the cases of chronic arthritis, osteitis, and periostitis are directly due to syphilis. A certain proportion of cases of cirrhosis of the liver, too, are caused by *spirochæta pallida*, but it is difficult to obtain any convincing statistics on this subject. Along with cirrhosis of the liver, we must mention the fact that positive Wassermann reactions have been obtained in cases of splenic anemia or Banti's disease, and in some instances these conditions seem to be dependent upon congenital syphilis.

Recently the importance of syphilis as the basis of certain cases of neurasthenia has been forcibly impressed upon me: Nonne and the French have always insisted upon this point, and I have recently seen at least two patients in whom the underlying cause for general ill health and severe neurasthenic symptoms seemed to lie in a chronic syphilitic infection (totally unsuspected), which lurked probably in the aorta.

The list of diseases which until this time had rather an obscure etiology, is quite a long one. I have time only to mention such conditions as paroxysmal hemoglobinuria, a disease which, according to recent reports, is almost constantly accompanied by a positive Wassermann reaction, and the appalling number of eye diseases which are dependent upon syphilis. According to Leber, excluding suppurative cases, the Wassermann reaction is positive in twenty-six per cent. of cases of retinitis, thirty-eight per cent. of iritis, and eighty-four per cent. of keratitis.

But the conditions in regard to the disease of the nervous system are perhaps even worse. Through the numerous investigations which have now been made upon the blood and spinal fluid in cases of paresis and tabes dorsalis, we know that for practical purposes both of these diseases are due to syphilis. Noguchi, by his beautiful demonstration of *spirochæta pallida* in brains from cases of paresis, has now set beyond a doubt the fact that paresis is not a parasymphilitic affair connected in some indefinite way with syphilis, but that paresis is syphilis itself.

The pathetic part about these cases of tertiary syphilis is that treatment is of such little avail. In a few cases the disease may be arrested and even the symptoms cured, but too often the damage has already been done, and though the life of the individual is spared over a few years, he

remains an invalid, hampered by a leaking heart valve, a partial paralysis, or a stiff joint. In many cases the therapeutic outlook is even less favorable, and finally in the paretic absolutely hopeless. If only these patients could be seen, a correct diagnosis made, and proper treatment given at the beginning of the disease! Then the cure is possible and all this needless expense and suffering could be prevented. The fight against tuberculosis has been carried out with energy and with most creditable sympathy and aid of the public. The fight against syphilis is perhaps just starting in earnest, and as compared with the difficulties which arise in the control of tuberculosis, syphilis should be a comparatively easy matter to attack. Co-operation of physicians, hospitals, the public health department, and the public seems to be almost the only means to reduce the incidence and unsuspected ravages of this ubiquitous disease.—*W. T. Longcope, in New York Medical Journal.*

A CASE OF HEART WEAKNESS TREATED WITH CANE-SUGAR.—Dingle (*The British Medical Journal*) reports a case of failing heart in a plumber, aged 28, which followed upon severe exertion several months previously and probably involved damage to the mitral valve.

The heart action was suggestive of some irregularity in the aortic valves. It was rapid, irregular, intermittent. There was decided ascites and some edema of the skin over the lower abdomen. The urine showed no albumin. Rest in bed, together with nourishing diet, tincture of digitalis, tincture of nux vomica, and magnesium sulphate failed to improve matters, nor did any modification of the drug treatment do so. The patient's condition became much aggravated, although very occasionally he seemed to be improving. The ascitic fluid was drawn several times.

Seven months after the patient had presented himself for treatment, and a little over one year after the first injury, the doctor commenced the sugar treatment, ordering the patient to take five ounces of Glebe's granulated cane sugar during the day, continuing, however, with small doses of digitalis. A few days later, all medicines were discontinued, with the sole exception of occasional doses of magnesium sulphate and calomel. The sugar was continued, usually in the full amount of five ounces during the day. There was occasional nausea. After one week some subjective improvement was noticed, which became more decided in the course of another fortnight. The appetite was good, the ascitic fluid did not increase, and the heart sounds gradually became more regular and the pulse stronger.

With one slight relapse, due to a mental shock, the patient continued to improve steadily and was practically well in a little less than six months after the cane-sugar treatment was instituted. Only twice since beginning the sugar treatment had the patient taken any cardiac drug, and then only for a few days. He never again required tapping; and the author attributes his remarkable improvement solely to the cane-sugar.

Another important point which the author makes, is that before beginning with the sugar, the patient was forced to take aperients almost constantly, but hardly ever took any at the time of the report.

THE CUTANEOUS REACTION OF SYPHILIS.—Wolfsohn, after quoting



Noguchi's method of preparing luetin and his method of applying his test, states that Noguchi showed that in order to cultivate the pallida directly from primary lesions in man two all-important conditions must be considered: (1) The maintenance of strict anaerobiosis; and (2) the property possessed by the spirochaeta of migrating in solid media in which it is multiplying.

The culture media used consists of ascitic fluid containing a piece of sterile placenta, and ascitic fluid agar, also containing a piece of placenta.

The organisms are grown for six to fifty days. After sufficient growth has taken place the tissue is removed, and the solid media and organism ground in a mortar and diluted with the ascitic fluid culture. The mixture is then heated for sixty minutes to 60 degrees C., and 1 per cent. trikresol is added as an antiseptic. Noguchi has called this final sterile emulsion "luetin," and this preparation has been used in reported cases. As pointed out by Noguchi, pure cultures of the *treponema pallida* offer many advantages because not only are pallida of different ages present, but also the metabolic products, these being important factors in establishing allergic states. The method adopted by Noguchi was strictly followed: Both arms of the patient were cleaned with 95 per cent. alcohol; 0.1 cc. of the luetin was injected intradermally into the left arm over the biceps muscle, and the same amount of the control emulsion (which consists of the media only and no pallida) was similarly injected into a corresponding site on the right arm. Observations were made daily thereafter over a period of twelve to thirty-six days.

To insure the sterility of the emulsions, cultures from them were frequently made.

Every patient upon whom the luetin test was tried had a Wassermann reaction done on his blood serum and upon his cerebro-spinal fluid, when this was indicated.

Very few reactions presented any difficulty in interpretation—i. e., practically all the reactions were definitely negative or positive.

In the majority of cases, twenty-four hours after the injection, the skin in the injected arm showed a slight blush and a moderate induration or papule formation. Very seldom was any tenderness or itching complained of, which has been only too frequent in the cases showing positive reactions.

Almost invariably, after forty-eight hours, the injected site would be free from induration and erythema; a pin-point ecchymosis or perhaps a small yellowish pigmentation alone remained. If the patient has irritated the site of injection a small pustule might form, but this latter has only developed in two of the control cases and has not given rise to confusion in interpretation.

Though the type of reaction in positive cases varies greatly, in general the gross characteristics are induration and erythema. In analyzing the various types of reaction found in the different stages of syphilis, the following classification includes all the essential varieties:

In the papular form arising at the site of the injection within twenty-four hours an indurated papule develops which varies in size from 5 to 15 mm. in diameter, and this is surrounded by more or less erythema and is usually quite tender. The reaction gradually increases in size until the

third or fourth day, when it either regresses or develops into the pustular form. The control injection (in the other arm) in these cases usually shows no reaction after twenty-four to forty-eight hours.

In the vesicular variety this is generally seen in cases in which a moderate reaction rapidly follows the injection, and it occasionally appears as a bleb, but more often as a group of small vesicles superimposed on an indurated, tender base. As a rule, the vesicular passes into the pustular variety.

The pustular form may be primary or secondary. When primary it occurs usually in association with the violent reaction seen in latent or in late tertiary stages of syphilis, where no treatment had been previously administered. When secondary it occurs in the papular form or develops early from the vesicular stage. The pustules usually rupture spontaneously with subsequent crust formation.

In a few latent and parasyphilitic cases a week after all evidence of reaction at the site of the injection had subsided a hemorrhagic pustule appeared, which when opened exuded a semifluid grumous hemorrhagic material.

The torpid form is the name aptly given by Noguchi to a variety. It was found that in many of the parasyphilitics, showing vascular luetic lesions, for three to seven and even twenty-eight days following the injections the reactions were quite negative; but in the site of injection, after this period of quiescence, possesses a bluish-red tinge, and a smaller or larger indurated papule is felt. This soon increases in size, is not tender, and in two or three days following develops into a pustule, after which there is a regression of the reaction. In these cases the control injection site showed nothing abnormal.

In brief, the reactions may be said to be (1) mild, (2) violent, or (3) torpid, according as the signs slowly develop to a maximum and regress; start in violently, reaching an early maximum, which is maintained for twenty-four to seventy-two hours, and then subside; or develop late and show only a mild reaction after a latent period and never become marked.

In no case did scar formation follow after local manifestations subsided, but in many instances there was more or less pigmentation, according as the site of injection was markedly hemorrhagic or not.

Of the seventy controls in which the patients were suffering from diseases other than syphilis—e. g., soft chancre, mitral insufficiency, myocardial insufficiency, cancer of the tonsil, acute rheumatic fever, pregnancy with still-born infant, senile palsy, brain tumor, hypophysis tumor, pernicious anemia, peliosis rheumatica, sarcoma of the ileum, myelogenous leukemia, pulmonary tuberculosis, chronic nephritis, rickets, infectious arthritis, etc.—when no history of syphilitic infection could be obtained, and where the Wassermann reaction was negative in each case, no positive luetin or control reactions were obtained. In two cases, small non-indurated pustules developed within three days after the injection, but these could be easily distinguished from the positive reactions. No constitutional symptoms were complained of or noted in these cases.

The Weil test for syphilis, though perhaps not largely applicable, is of interest from the fact that Weil claims for it much greater activity in cases of latent syphilis than any hemolytic test. He also states that fol-

lowing treatment it long remains positive. He found that syphilis rendered blood corpuscles resistant to the hemolytic action of snake venom. In the application of this test the patient's blood is washed thoroughly in a two per cent. solution of sodium citrate. The venom of the cobra diluted 1:10,000 to 1:40,000 is added to the tube containing the washed corpuscles, and this is incubated. Absent hemolysis in dilutions up to 1:20,000 is regarded as positive. The slightest degree of hemolysis in the tube diluted 1 to 30,000 is a negative, and a strong negative is present if there be the slightest trace of hemolysis in the last tube—dilution 1 to 40,000.

In syphilis of the nervous system "cyto-diagnosis" is of some aid. A predominance of lymphocytes in a clear fluid indicates either cerebrospinal syphilis, tabes, or tubercular meningitis. An increase in polynuclears points toward an acute meningitis, though in mixed infection there may be pus in a tuberculous condition.—*Bulletin of Johns Hopkins Hospital*.

THE TREATMENT OF POST OPERATIVE METEORISM WITH PERISTALTIN AND PHYSOSTEGMIN INJECTIONS.—Koch (Giessen), after reviewing the causes of post operative meteorism and the desirability of possessing other than the ordinary means of treating such conditions, speaks of hormonal, and says that associated with its action upon the intestines there is a very objectionable fall in blood pressure, which in some instances may become dangerous. Indeed, it is a question whether its action upon the intestinal function is not secondary to the diminished blood pressure produced.

He then speaks of peristaltin, a glucoside produced from cascara sagrada, and readily soluble in water. This is a constant chemical substance whose composition is well known. It is obtainable in sterile ampules containing 0.5 gr. Four authors are quoted who have studied the action of this promising drug. The author himself has seen remarkably good results in 32 cases, including all sorts of abdominal operations. He compares its action with that of physostegmin, and believes that its effects are expended mainly upon the lower bowel, while physostegmin seems to act mostly upon the smooth fibre of the small intestines. The drug acts from one quarter to one hour after injection. In some instances an enema seems to hasten its action.—*Zentralbl. f. Gyn.* 1912—1331.

THEODORE J. GRAMM, M. D.

THE TREATMENT OF LOW BLOOD PRESSURE IN PERITONITIS.—Klotz (Tubingen) says the cause of low blood pressure in peritonitis is a paralysis of the splanchnic nerve, and heart injury only sets in secondarily. The injury to the peripheral vessels is shown by their relaxation. In pituitrin we have a remedy which causes a prolonged rise of blood pressure and at the same time removes intestinal paresis by stimulating peristalsis, and also increases diuresis. These actions were first demonstrated in animal experiments and later observed in the human being. The author mentions two cases in bad condition who were saved. The first was a woman having a ruptured uterus who entered the hospital pulseless. She was operated by extirpation, with drainage above and below. On the fourth day the pulse failed, collapse, increased respiration and diarrhoea. From intravenous pituitrin injection the patient improved for thirteen hours, when



the injection was repeated with salt solution. The patient recovered. In the second case collapse set in two days after operation of an infected condition, and the same treatment together with drainage saved the patient. In such cases the action of the remedy without drainage is only transient.—*Zentralbl. f. Gyn.* 1912-1301.

THEODORE J. GRAMM, M. D.

TECHNIQUE OF ABDOMINAL SECTION.—At the sixth International Congress for Obstetrics and Gynecology, under the general heading of the treatment of the peritoneal wound, K. Franz has given a statement of what may be regarded as the generally accepted technique. He says it is not possible to operate with entire freedom from germs. All bacteriological examinations of the peritoneum after operation have shown the presence of bacteria but which cause no particular harm for they are not numerous and not virulent and are consequently soon destroyed. But this is only the case when accurate asepsis is observed during the operation. Gloves should of course be used. The numerous germs from the air are harmless. On the other hand the greatest danger threatens from autogenous germs. To combat these we have no remedy except the operative technique. Such autogenous germs may come, for example, from necrotic tumors of the ovary with torsion of the pedicle, carcinomata, disintegrating myomata and from the intestines and bladder. Intestinal bacteria are especially to be feared, and they cannot be destroyed by chemical means, but only by means of the technique. The virulence of bacteria from vaginal and cervical cancer may be destroyed by 70 per cent. alcohol or iodine tincture. Streptococcus and bacterium coli are the most dangerous for the peritoneum, and yet the peritoneum is quite resistant to infection for we see abscesses of the abdominal wall while only a slight reaction occurs in the peritoneum. Bacteria within the abdomen are taken care of by two protective means, namely, by resorption and especially by the formation of an exudate. The less the peritoneum is injured the greater is its bactericidal powers. The exudate should not be diluted with salt solution. From all of the above may be deduced the general principles of the peritoneal wound treatment. Unabsorbable suture material should not be used, since germs may collect upon it, hence catgut is advised. If possible, vaginal operations are preferable to abdominal. It is always best to operate dry, the mops and gloves also being dry. Fluids entering the abdominal cavity should mostly be removed, but in a cautious and gentle manner. Raw surfaces should be carefully covered. Dead spaces under the peritoneum must be drained. In general peritoneal drainage is rarely indicated, and only when large wound surfaces must be left, especially when they have been soiled with pus. Drainage toward the vagina is preferable; but if not practicable the Mikulicz tampon may be used and is better than a rubber or glass drain. Prophylactic oil injections or of salt solution, or peptone, etc., should not be used.—*Zentralbl. f. Gyn.* 1912-1297.

THEODORE J. GRAMM, M. D.

## Monthly Retrospect

### OF HOMOEOPATHIC MATERIA MEDICA AND THERAPEUTICS

CONDUCTED BY DR. DONALD MACFARLAN  
PHILADELPHIA

THE BRITISH INSURANCE ACT AND HOMOEOPATHY.—In the address delivered by Dr. E. B. Roche, president of the British Homœopathic Society, at Chalmers House, the terms of the National Insurance Act were brought out especially as regards the position of homœopathic practitioners of medicine. Dr. Roche, as president of the British Homœopathic Society, spoke on the invitation of the British Homœopathic Association. All of the data especially that relative to the dispensing of medicine has not been cleared up as yet. The terms of the Act secured the primary rights of those who were believers in homœopathy, both doctors and patients. This was an important point, as for the first time in this country, it became the right of a homœopathic practitioner to take a public appointment, and receive payment from the public funds. Salient to an important part of the Act are the following remarks *verbatim* from this important address:

"But in many places there is no homœopathic chemist, and the question was asked again and again, how can we deal with this question of dispensing if we go on the panel? May we give our own medicines free of charge, if we choose so to do, as we have always done? Or, will the Commissioners allow us, as there is no available chemist, to have the money appointed for medicine as in the case of a doctor in country places, or a part of it, leaving the rest for external applications and appliances obtained from the chemists? Or, may a doctor where there is no chemist, obtain a supply from a given authorized homœopathic chemist, and send prescriptions to him.

"These questions as to the supply of medicines by homœopathic panel doctors, have been laid before the Insurance Commissioners, and await decision."

CLINICAL VERIFICATIONS OF TUBERCULINUM.—From various cases, it would appear that the tuberculinum patient is a very sensitive person, mentally and physically; extremely sensitive to pain; sensitive to noise; to touch; intolerant of clothing; subject to deep brain headaches and intense neuralgias.

Mental depression is deep, and mental symptoms are marked, sometimes bordering on insanity.

There is marked craving for fresh air, with < from dampness;  
< from becoming wet; from any draught; often from wind.

The patient is < in the early morning and after sleep.

< from bathing is found in some cases.

Tension all through the body appears to be characteristic, most marked in nape of neck and down the spine.

General exhaustion is a strong feature; nervous weakness and weariness.

Quiverings; tremblings; pulsations; faintness.

Sensation of suffocation, even with plenty of fresh air.

Chilliness between shoulders, or up the back.

Many stomach and bowel disturbances, including rectal hemorrhage. Easy nausea.

Menstrual disturbances prominent.

Sleep poor; waking early or over-powering sleepiness in daytime.

Dreams vivid and distressing.—*The Homœopathician*.

**PODOPHYLLUM IN DIARRHEA.**—The use of *podophyllum peltatum* in the cure of diarrhetic states has been brought out by Dr. R. Haehl, of Stuttgart. One of the characteristic symptoms of this remedy is a morning diarrhea, the first half of which consists of firmly formed hard feces, followed by thinly fluid stools and flatus.

Although *podophyllum* influences also other organs or parts of the body, e. g., the nervous system, the eyes, the female sexual organs, etc., the provings do not allow us to doubt that its chief domain is the mucous membrane of the intestines. Dr. Anstie, who has given this remedy many trials on animals, has established the fact that it causes a congestion of blood in the mucous membrane of the small intestines, so that this is frequently covered in its whole length with a bloody mucus.

The most striking effect is found in the duodenum, the inner surface of which frequently showed destruction of the tissues and ulceration. Where it enters the large intestine, these irritations caused by *podophyllum* usually ceased and only in a few cases could there be found some scattered spots in the larger intestine with the morbid action of *podophyllum*.

On the other hand, the action of *podophyllum* was all the more manifest in the rectum. In children suffering from dysenteric bloody diarrhea, with violent urging and severe relaxation of the rectum, so that this protrudes during stools, it will be found of great service. So also it is a reliable remedy in internal and external piles. This symptom may be connected with the congestion of the liver and stagnation of the circulation in the portal vein, which has been observed by numerous provers, whether *podophyllum* is able to act on the liver directly is not, as yet, decided. Dr. Anstie, grounded on a number of his experiments, came to the conclusion that the disturbances caused by *podophyllum* in the liver and in the flow of the bile, are only indirect effects caused by the transition of the morbid changes of the duodenum, which are transferred also to the gall-bladder, or that the flow of the bile from it is interfered with.—*Homœopathic Recorder*. Translated from *Hom. Monatsblätter*.



**DOLICHOS PRURIEUS.**—This remedy acts strongly upon the liver and gastro-intestinal tract. The whites of the eyes and the face are yellow. Jaundice developed early in the proving, with white clay-like stools. There was a strong taste of blood in the mouth of the provers. There is much colic and flatulence in the abdomen, with a bruised pain in the left umbilical region. Great itching accompanies the jaundice of this remedy. In this it is somewhat similar to chelidonium. It is also to be thought of in pregnancy, where the patient constantly complains of a large lump in the throat. Nervous affections of children is another consideration of this remedy, for like cina, these patients are constantly annoyed with worms, and convulsions due to worms. They have white stools, constipation, thread worms, chronic spasms with eyes fixed and wide open.

**Skin Symptoms.**—Violent itching of the skin all through pregnancy or jaundice, or constipation with clay-like stools (lyc., pod.). The itching is greatly aggravated at night, preventing sleep.—*The Critique.*

**DRUGS IN MANIAC CASES.**—In a recent and admirably well written article on "Drugs in Maniac Cases," Dr. C. A. Potter, at the State institution at Gowanda, proves conclusively the superiority of homœopathic treatment in the cure of those mentally unbalanced.

In the first place he calls attention to a few simple figures which are interesting from our viewpoint as homœopaths. These are compiled from the statistics given in the reports of the New York State Hospital Commission for the past nine years, 1903 to 1911 inclusive. For the years 1903, 1906, 1908 the homœopathic State institution either at Middletown or at Gowanda had a recovery rate of from 40 to 44 per cent. In 1906 and 1908 these institutions held first and second place in the record of recoveries.

During this same period, of nine years, not one of the eleven old school State hospitals attained a recovery rate as high as forty per cent., and in only two of the nine years considered do we find the old school institutions with the highest recovery rate (Long Island 1905. Utica and Long Island 1907). Besides this every year from 1903 to 1911 inclusive either Middletown or Gowanda has had the lowest death rate, Gowanda in 1904, 1905 and 1906 and Middletown in the other six years.

Assuming, then, that general methods of care, hospital routine, environment, etc., are practically the same in all of our State hospitals, is it not quite evident that medication, the one thing on which we differ, is responsible for our success in returning a greater number of patients to their normal condition? And here let us note that it was Hahnemann himself who first called special attention to the importance of mental symptoms even in physical disease.

Aconite is often overlooked in mental cases, possibly from the fact that the patient has not a very high temperature and you consider that essential. This is an old school idea. The valuable indication for aconite in mental cases, as well as in physical disease, is anxiety, mental distress, leading naturally to fear of impending misfortune or even of death, when in reality the patient is not at all in a critical condition. These are the symptoms, with restlessness and tossing about the bed, that call for

aconite, and no matter what the delusional condition never give aconite to patients in a mild, calm, even mental state. It is the active brain that calls for this drug in both mental and physical diseases.

Belladonna is in a way similar in its action to aconite although best suited to more furious and violent cases, in which the restlessness and tossing about occur chiefly at night, together with fear, suspicion and a desire to get out of bed and run away. In some violent cases the patient strikes, spits, bites and tears, at times growling and barking like a dog. Such a patient will sing and laugh, apparently good naturedly, but when approached will clutch at your clothing, pulling and biting like a vicious animal. Belladonna also fits a depressed condition with desire to die and inclination to suicide, which should be kept in mind when prescribing for mental cases. This drug is followed with much success by *calcarea carb.* after the active symptoms have subsided.

It is difficult to differentiate *hyoscyamus* from belladonna although the general physical characteristics of a belladonna type should make it simple. *Hyoscyamus* is milder than either belladonna or stramonium and suits noisy, boisterous, loquacious patients who are occasionally irritable but usually good-natured, jolly, inclined to make a jest of everything and even silly. Such a patient is jealous and suspicious of every one, more obscene, lewd and lascivious than the belladonna or stramonium patient, tirelessly active, and often runs about out of the house at night without clothing. The inclination to be naked is in part due to the sensitiveness of the skin. *Hyoscyamus* is similar to *veratrum alb.* minus the melancholy phase.

*Veratrum alb.* is indicated for patient who is full of activity, whistles, sings, yells and exhorts and possibly the next minute will brood and pray for salvation. Such patients have extravagant, haughty ideas and an inclination to claim for themselves affections which are altogether imaginary.

Stramonium is for the typical delirium of alcoholism, with visions of animals, demons and crawling things. An ungovernable fury, terror and desire to run away are the natural consequences of these horrible illusions and hallucinations. In a milder form such patients have a clownish behavior which alternates with sadness and seriousness.

Anacardium is the typical swear remedy, according to certain text books, but I have failed to note any remarkable improvement in our patients from the administration of this drug. I believe, however, that in patients manifesting the typical physical symptoms, together with irritability and a disposition to take everything in bad part even to the extent of becoming violent, we derive much benefit from it. Another symptom which also calls for anacardium is a peculiar feeling as though the patient was controlled or dominated by more than one will, and as a result knows not what to do or where to turn.—*N. A. J. of Homœopathy*, March, 1913.

**DUODENAL ULCER.**—By T. Miller Neatby, M. A., M. D. Cantab., M. A. Lond. Assistant Physician to the London Homœopathic Hospital.—In the treatment of this diseased state Dr. Neatby considers that *chelidonium* is specially indicated where the ulcer is accompanied by a general duo-

denal catarrh which tracks up to the liver and causes jaundice and pale costive stools. In duodenal ulcer there is often a pain in the neighborhood of the inferior angle of the right scapula, and this is a strong mark of chelidonium. There is also distension and epigastric or right hypochondriac pain going through to the back and relieved by taking food and especially by drinking hot liquids. There is also the symptom "ailments brought on or renewed by change of weather." These symptoms are all closely related to duodenal ulcer. There is doubt if chelidonium goes deep enough, though it will certainly often relieve. One of the cases treated by Dr. Neatby was relieved by chelidonium, but it was not until graph. was given that the patient was cured.

Anacardium is closely related to forms of nervous dyspepsia and gastralgia that are often the precursors of duodenal ulcer. It has distension and eructations and above all things a "stomach" pain coming on a long time after meals and relieved by eating. It also has constipation with inactive bowels.—*British Homœopathic Journal, March, 1913.*

ERIGERON CANADENSE.—This plant, which is often commonly designated Canada fleabane or pride weed, is of the natural order of compositae-asteroideae. It is an indigenous annual plant, with a stem from two to six feet in height, being covered with stiff hairs and divided into many branches. The flowers are very small, numerous, white and arranged in terminal panicles. They differ from those of the other species of erigeron in having an oblong calyx, the rays very minute and more numerous than the florets of the disk, and the seed-down simple. Canada fleabane is very common throughout the northern and middle sections of the United States and has become naturalized in many parts of Europe. It abounds in neglected fields and blooms in July and August. It is a most valuable remedy in *bleeding states*. A woman, for example, has an abortion and does not get along well. She is low spirited; sense of great languor is present. The flow may be quite normal for a few days then comes on a profuse flow of bright red blood; the flow is increased by every movement the woman makes. Now this is undoubtedly a case where all the secundines have been expelled and we do not look for trouble. Yet the trouble does come and comes a-plenty. For these bleeding states, erigeron proves of great value. It in fact helps all cases of menorrhagia. It is indicated also in the pregnant woman when there is seemingly a weak uterus. In these cases there is often demonstrable a bloody discharge subsequent to a slight fall or some overexertion. It is by the timely use of this remedy that your fears of a miscarriage have disappeared and your patient speedily becomes her normal self. Also in cases of bloody lochia which gets uncontrollable this remedy proves of great worth. In uterine hemorrhages, also, of long duration and when other remedies did no good erigeron canadense acted promptly in checking the trouble. This has been verified many times. Turpentine (high) has about the same effect. Terebinth (turpentine) is also of inestimable value in abdominal distension in typhoidal states, when you have a greatly distended abdomen as a consequence of a terrific gaseous bellowing of the gut.—*Proving by Fahenstock (J. C.) and others.—The Critique.*



MUSICOTHERAPY.—The second series of Cabanès upon *Remedies of a Former Time* have recently appeared. This work besides many interesting chapters on the holy doctors, the cult of the stones, trees and waters, of kingly curers, of the influence of odors and perfume on the human organism speaks delightfully on the power of music in the cure of disease. "La musique dans les maladies" forms one of the most interesting in the book. We see the assuagement of King Saul in his furious obsessions by the gentle harp of the youthful David—of the musicotherapeutic successes of Coelius Aurelianus, of Aulu-Gella, and of Theophrastus. Nearer our own time, we are acquainted with the treatment by music and by song of the melancholy of King Philip V of Spain by Farinelli—and of the Princess Belmonte Pignatelli by the German singer Don Pedro. During the seventeenth and eighteenth centuries many works on musicotherapy appeared. A host of curious anecdotage is contained in these numerous works. Grétry cites a curious auto-observation personally: "I put," writes he, "three fingers of my right hand on the artery of my left arm, or on any other artery of my body; I sing to myself an air the movement of which is of the rhythm of my pulse; after a time I sing with gusto an air whose movement is different: then I feel distinctly my pulse accelerate or slacken in direct accord with the movement of the new air." Similar effects are observed by Berlioz and by Malibran, with an intensity up to the stage of vertigo, convulsions and syncope. Récamier was accustomed to prescribe to his more fortunate patients, music in the form of tambourine *séances* for disorder of the stomach because he considered *rhythmic harmony* acted marvellously on that important viscus! We may in fact pass before our visions what is more or less legendary as well as that which probably belongs to the domain of truth, as generally interpreted. On the one hand we read of the immortal Beethoven curing a phthisic lady while composing for her and before her *The Sonata to the Light of the Moon*; of Alibert, the author of the "Physiology of the Passions," leading back to health, in conjunction with the violincelliste Bénazet, those patients with chest lesions in ten or twelve sittings; of Corvisart, curing typhoid fever in an adolescent by the good offices of two horns, two bassoons, two clarinets and a trumpet, a cure of which the authenticity is vouched by MM. Hallé, Leroux and Husson. Let us pass, however, to musicotherapy in mental conditions. Here it really is of incalculable value. Meyerbeer warded off an insanity by his modulation of Alice at the foot of the cross. Drs. Berschinsky and Berberoff by experimentation with No. 2 of the brilliant waltzes of Chopin have cured night terrors. So in one way and another both in the state of health and disease music is of great value—in disease in the role of antispasmodic, antidyspeptic and soothing agent. With a proper choice of both instrument and composition it is always useful, salutary and agreeable.—*"Remèdes d'autre fois" par le Dr. Cabanès.—A. Maloine, Editeur.*

# THE HAHNEMANNIAN MONTHLY.

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JULY, 1913

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## THE DIAGNOSIS OF SURGICAL DISEASES OF THE STOMACH.

BY

ERNEST F. SAPPINGTON, M. D., WASHINGTON, D. C.

THE day of exploratory operation in the diagnosis of surgical diseases of the stomach is past. Modern diagnostic methods now accurately reveal stomach secrets that have long been hidden. These secrets have been named "gastralgia," "nervous indigestion," "dyspepsia," "heart burn," and many similar names that mean nothing to the physician and less to the patient.

This meaningless nomenclature originated in the days when it was impossible for the physician to know what the real trouble was. He was obliged to make some diagnosis to satisfy the patient, and "nervous indigestion" seemed to answer all the requirements and conditions, for all patients with stomach disease are more or less nervous.

From the standpoint of etiology all stomach symptoms can be placed under three headings:

1.—Those caused by diseases of distant organs, i. e., brain tumors, tabes, tuberculosis, pregnancy, valvular diseases of the heart, Addison's disease, etc.

2.—Those caused by organic diseases in the neighborhood of the stomach.

(a) Diseases that do not disturb the anatomy of the stomach.

(b) Diseases that cause secondary changes in the stomach.

3.—Those caused by diseases of the stomach itself.

(a) Organic diseases,—ulcer and carcinoma.

(b) Functional diseases,—secretive neuroses, catarrh, ptosis and atony. (Haudek.)

The clinical differentiation between intra and extra ventricular tumors by the older methods is not possible. Tumors of the pancreas, spleen, gall bladder, omentum and transverse colon, may all simulate tumors of the stomach. The accurate diagnosis of these tumors is only possible by the newer methods of stomach diagnosis.

Organic changes in the stomach wall cannot always be clinically demonstrated. Vomiting and pain may be due to causes other than disease. The abdomen may be so rigid that palpation is not possible. Even after the stomach has been inflated, palpation is often unsatisfactory. The same is true of percussion.

The finding of blood in stomach contents or in stools, is not always possible even though present, and even when demonstrated it is often impossible to determine its origin.

The chemical examination of the stomach contents does not always give conclusive evidence. Ulcer and hyperchlorhydria have in common increased Hcl; while carcinoma and achylia have diminished or lacking Hcl. On the other hand, we may have gross changes in the stomach wall with apparently normal chemical findings.

In carcinoma of the gall bladder and of the pancreas and transverse colon, there have been found repeatedly, diminished total acidity, no Hcl, and positive lactic acid.

Let us discuss here the clinical differential diagnosis between ulcer and carcinoma, in order that we may properly interpret the numerous symptoms these patients have. As soon as we have demonstrated the presence of a tumor, the question immediately arises, is it ulcer or carcinoma, or both?

Of first importance is the history. After close questioning we frequently find that these patients have had a "weak stomach" for years, sour eructations or vomiting; this period followed by an interval free of symptoms, then a period of most severe symptoms.

This history is typical for a penetrating callous ulcer. Even in patients of the carcinomatous age in whom many symptoms pointing to ulcers have been lost, and those present were indicative of carcinoma, there have been found chronic ulcers that were the sole causes of their years of suffering.

The history of the ulcer patient is characterized by the inter-



mittence of the symptoms. Periods of complete freedom from symptoms, with a gain in weight, will be followed by symptoms of such severity that carcinoma may be suspected. This is true for ulcer of stomach as well as ulcer of duodenum.

In a case of carcinoma, there may also be a temporary improvement during the course of the disease. The explanation of this lies in the fact that there is an ulcerative process at the pylorus which leads to a change in the chemical contents of the stomach. This may cause a spasm of pylorus; later there is a pyloric insufficiency. This holds true only in cases in which the pylorus is not involved. In carcinoma of pylorus the symptoms increase rapidly and constantly.

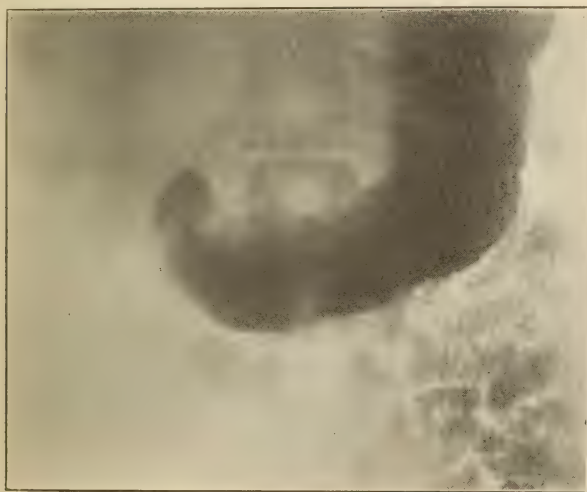


FIG. 1.—NORMAL STOMACH.

Note position of pylorus to right of vertebral column; regular contour of stomach walls; food passing through pylorus into small intestine; moderate quantity of bismuth meal in small intestine. Picture taken three-quarters of an hour after bismuth meal.

The character of the pain is significant. The dull, pressing, poorly localized pain in the region of the stomach after the taking of nourishment speaks for carcinoma. The circumscribed, boring, strong and radiating pains, that subside and recur again, speak for ulcer.

Obstipation may occur in both conditions. There may be extreme emaciation in ulcer when the symptoms are so severe as to prevent the taking of food. There may be a tumor present in both carcinoma and ulcer.

The inflammatory tumor that the chronic ulcer forms is more tender, less defined as to its borders, than the carcinoma, is smooth and very early adhered to neighboring organs. The adhesions occur most frequently towards the liver and pancreas. The ulcer tumor occurs less frequently at the pylorus, and more frequently on the small curvature or posterior wall of the stomach.

In consequence of the chronic catarrh these cases lose their hyperacidity.

After the abdomen has been opened many cases have been



FIG. 2.—SPASM OF PYLORUS DUE TO ULCER AT PYLORUS.

Note dilatation of cardiac end of stomach and fermentation in stomach shown by light striations through contents. Picture taken one hour after ingestion of bismuth meal. Atropin and milk diet did not relieve this spasm. Gastro enterostomy is indicated.

diagnosed and operated as cancer, when the histological examination showed only ulcer.

Because of the uncertainty of these symptoms, and because there was no positive way of making a diagnosis of stomach diseases, Rieder suggested the use of the bismuth meal and the examination of the stomach by means of the Roentgen ray.

This meal consists of 300 grams of gruel to which is added 40 grams of bismuth carbonate. (In my own practice I am using buttermilk in place of the gruel very largely. It appears to be more easily taken and its action on the stomach fully as good.)

This meal should be taken after a fast of 12 hours, and the

stomach immediately examined by means of a medium hard Roentgen tube and Barium screen.

There is a well defined shadow projected on the screen, and from the study of this an accurate diagnosis can be made.

#### I.—The Roentgen Physiology of the Stomach.

This has reference to the:

- (a) Form.
- (b) Location.
- (c) Size.
- (d) Tonus of the musculature.
- (e) Filling of stomach.

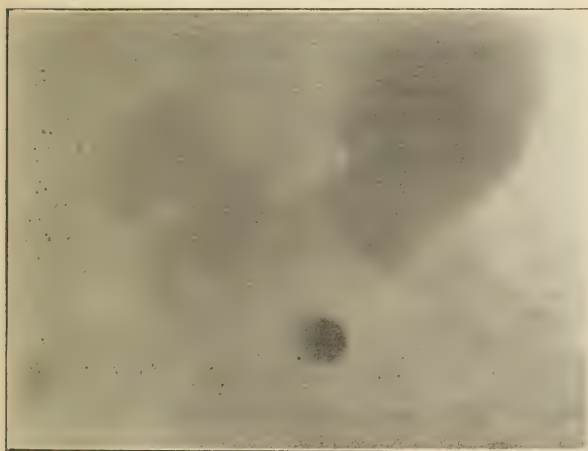


FIG. 3.—CARCINOMA OF PYLORIC ANTRUM.

Note large quantity of bismuth just out of pylorus into duodenum and in small intestine; narrowness of pyloric end as compared with cardiac end (contracted stomach). Filling defect sharply outlined. This case is operable because of movability of stomach and large part not involved. Picture taken about three-quarters of an hour after bismuth meal. Carcinoma probably of fungus type. Compare with Fig. 4.

The form may be cow-horned, I, or hooked shape. The cow-horned variety is found in robust, broad-chested and deep abdomen men, the I-shaped in vigorous women, and the hooked-shaped in tall slender individuals. This is the form that frequently leads to a gastropotosis.

In women the stomach is nearly vertical, and is located almost entirely to the left of the median line. In men there is a tendency to the horizontal position, about two thirds of the organ being to the left, and one third to the right of the median line.



The stomach is very variable in size. Normally it descends as low as the umbilicus.

The tonus of the stomach plays a great role in the process of digestion. The functions of the musculature are two:

Peristole—Tonus.

Peristaltic—Movements.

The normal stomach should be empty in  $2\frac{1}{2}$  to  $3\frac{1}{2}$  hours. Because the time of emptying depends partly on the kind and quantity of food consumed, this time is usually extended to six hours.

The tonus may be hyper, hypo, or atonus. The hyper tonus stomach is wide at the cardiac end, narrow at the pyloric end. The peristaltic waves are deep, and the time of emptying shortened to  $1\frac{1}{2}$  to 2 hours.

In the hypo tonus stomach the peristaltic waves are shallow, and the time of emptying is 4 to 5 hours.

In the atonus stomach the waves are scarcely visible, and the time of emptying is 4 to 7 hours.

Haudek divides the stomach into,—pars cardiac, pars media, pars pylorica and antrum pylorica.

Holz knecht thinks there is a sphincter at pylorus and a sphincter at antrum. When one is opened the other is closed. If we compare the width of the pars media to the pars pylorica, in hyper tonus it is as 4 to 2; in normal condition as 4 to 4; in hypo tonus as 2 to 4, and in atonus as 0 to 4.

The air bubble is in cardiac part of stomach. When stomach is receiving food the pylorus is closed. In hyper acidity the pylorus remains closed too long. This is known as spasm of the pylorus.

In achylia we have pyloric insufficiency, in which the food remains in the stomach too short a time. Infiltrating carcinoma at the pylorus may produce insufficiency also.

An old scar, tumor or adhesions about pylorus may cause stenosis. A gastropotosis may also cause stenosis by kinking duodenum.

Six hours after taking the bismuth meal the stomach should be empty; two thirds of meal should be in colon, and one third in ilium. This is normal motility. If there remains a residue in stomach and the peristaltic waves are regular and deep, then there is present a pyloric stenosis or spasm. If the waves are not deep, we have to deal with an atonic stomach. If we put

the patient on a milk diet and atropin for a week, the pyloric spasm will disappear.

## II.—The Pathology of Ulcer and Carcinoma.

The contour of the normal stomach when filled with the bismuth meal is regular. The normal peristaltic waves make regular curved indentations.

The irregular outline of the stomach walls is known as the "Filling's Defect." This may be caused by,—tumor, ulcer, lobe of liver, spasm, food previously ingested, pressure from without, foreign bodies, folds.

In this paper we will discuss ulcer and carcinoma only.

Ulcer causes the highest degree of pyloric stenosis. The



FIG. 4.—CARCINOMA OF PYLORUS.

Note large amount of bismuth in large intestine (pyloric insufficiency); small shrunken stomach; irregular outline of Filling Defect. Picture taken immediately after bismuth meal. Carcinoma infiltrans. Inoperable.

most important diagnostic sign in the diagnosis of ulcer is the "Nischen" symptom of Haudek. This is a bulging outward on the small curvature, in the bottom of which is a small quantity of bismuth, then a layer of fluid, and on top air. This small cavity is external to the stomach and communicates with it. This corresponds to the cavity of a chronic, crater-like or penetrating ulcer.

As a direct result of the ulcer we have a drawing in of the opposite wall towards the ulcer. This may lead to the formation of hour-glass stomach. This hour-glass contraction may

be due to spasm of stomach, or to pressure from neighboring organs.

When due to these causes, the bismuth meal can be pushed from the lower part of stomach into the upper part by the hand of the examiner.

The hour-glass stomach due to ulcer, has a short canal that unites the upper and lower parts. These are dilated and their contour regular. This canal is near the small curvature. The tender point is on the small curvature, and we may palpate a tumor due to peri-gastritis. We judge the degree of contraction according to the residue of bismuth, to the size of the canal, and to the dilatation of the upper sack.

In ulcer, the cavity of the stomach is enlarged, due to the spastic condition of the pylorus. In the presence of peri gastritis, the stomach is not freely movable, and can only be moved by moving the organs to which it is adhered.

In the aged, we may have callous ulcer or ulcer due to arterio sclerosis.

For ulcer, then we may have on the Roentgen screen or picture:

The "Nischen" symptom.

The residue in stomach due to spasm of the pylorus.

Deep peristaltic or anti-peristaltic waves.

Dilated stomach.

Because of the fact that many competent observers believe that all carcinomas of the stomach develop upon an ulcer basis, the early recognition of ulcer of the stomach is of great importance. This early recognition is only possible through a careful study of the Roentgen picture. Carcinoma of the stomach produces a very characteristic picture.

During the transitory stage, i. e., the time when the ulcer is changing into carcinoma, the patient may show marked improvement of all symptoms, and the physician may be led to believe his patient is regaining health.

The Roentgen picture will explain this. During the ulcer stage, most of the symptoms are due to the associated pyloric stenosis. Just as soon as this ulcer begins to change to carcinoma the pylorus is relaxed and the food passes out of the stomach in normal time.

If the ulcer is at the pylorus, this improvement is due to an infiltration of the pylorus by carcinomatous tissue, with a consequent dilatation of pylorus. If the ulcer is located elsewhere,



the change is due to the lessened amount of Hcl. In carcinoma of the stomach, pyloric insufficiency is the rule.

The "Filling's Defect" is sharply irregular, like saw teeth. The stomach wall is thickened. If the carcinoma is at the pylorus, the defect is sharp as if the pylorus had been amputated. If it is on the small curvature, we have an hour-glass contraction. The contour of the two pouches near the constriction is sharp (saw-toothed), the canal is long and is in the median line of the stomach, and the entire stomach is small and shrunken.

This is quite different from the ulcer contraction.

It is not only possible to diagnose ulcer and carcinoma of the stomach by means of the Roentgen ray, but also to tell if the case is operable. The penetrating ulcer located high up on the small curvature, associated with peri-gastritis, is inoperable. The extensive adhesions make it impossible to draw the stomach forward into the abdominal wound. If these adhesions are broken up, a fatal peritonitis results. These adhesions cannot be seen by means of the Roentgen ray, but the fixation of the stomach, or the drawing of neighboring viscera, or vice versa, is sufficient evidence to warrant such a diagnosis.

In reference to the operability of carcinoma, the following questions arise:

- (a) The kind of carcinoma.
- (b) The location.
- (c) The extent of the carcinoma, and involvement of the neighboring organs.

As to the location and extent, what has just been said in reference to ulcer, is true of carcinoma. In the Roentgen picture, we distinguish three kinds of carcinoma:

The fungus carcinoma.

The carcinoma of ulcer basis.

The diffuse infiltrating carcinoma. (Haudek.)

We have discussed the carcinoma of ulcer basis.

The "Filling's Defect" in the fungus carcinoma is sharply outlined in contrast to the healthy stomach wall, and frequently does not change the size or form of the stomach. These cases if seen early, can be resected and are operable.

The diffuse infiltrating variety seldom makes a pronounced "Filling's Defect," but may contract the entire pars pylorica or media. In the latter case, we will have an hour-glass stomach and the pars cardiac will be markedly dilated; the pars py-

lorica small and shrunken. These cases are not operable for the following reasons:

(a) The high and inaccessible location of the carcinoma.

(b) Because the stomach is firmly fixed by adhesions, and the greater part of the stomach wall is infiltrated by carcinoma.

#### SUMMARY.

Symptoms pointing to stomach distress usually have a cause other than simple indigestion. This cause is usually some organic change in the stomach. This change can be diagnosed by means of the Roentgen picture long before it can by the usual methods of procedure.

Ulcer and carcinoma can be differentiated long before the presence of a palpable tumor.

Nearly all cases of ulcer and carcinoma are surgically curable if diagnosed in the early Roentgen stage.

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### THE DIAGNOSIS OF FEVERS OF OBSCURE ORIGIN (CRYPTOGENIC FEVERS).

BY

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(Read before the Homœopathic Medical Society of New York City.)

Not infrequently the physician is called upon to attend a patient whose only manifestation of ill health is a daily rise of temperature of one, two or even five degrees above the normal. If the fever continues but a few days and the outcome of the case is favorable, the patient and the physician are usually satisfied with a diagnosis of "catarrhal fever" or "influenza." When, however, the fever continues unabated for a week or more, both the importunities of the patient and his family and the necessity on the part of the physician of definite knowledge on which to base the sanitary and therapeutic management of the case, make it urgent that an accurate diagnosis of the cause of the fever should be made.

These fevers of obscure origin are among the most practical and interesting diagnostic problems that confront the internist and often it is necessary to exhaust every diagnostic procedure that modern medical science affords, in order to demonstrate their exact etiology.

I have now under my observation an unusual case of cryptogenic fever that for eight weeks baffled the diagnostic skill of several clinicians, bacteriologists and pathologists who had the opportunity to study it. A brief resume of the history of the patient will possibly prove interesting and will, as well, serve to illustrate some of the difficulties that we encounter in the diagnosis of such conditions:

Patient, Sophie K. Age twenty, single, American by birth; occupation, weaver.

*Family History*: Parents living and well; no history of any hereditary disease in the family.

*Past Personal History*: Had diphtheria at two years of age, following which she had a chronic otitis media which persisted for a number of years. Had an abscess in the neck which opened and discharged at ten years of age; otherwise has been in excellent health until the onset of the present illness.

*History of Present Illness*: On the 20th of January, 1913, the patient was taken sick while at work. The attack began with weakness in the legs and general malaise. The patient continued at work throughout the day, but the following day remained at home and in bed because of weakness and a general sick feeling with dull pains in the small of the back, aggravated by moving. A physician was called the following day and found her temperature to be 103°. Aside from loss of appetite and thirst there were no complaints.

The patient was admitted to the Hahnemann Hospital on the 26th of January at which time she had a temperature of 103.6°, pulse 81, respiration 18. Careful questioning elicited no complaints except a slight headache and loss of appetite. Patient was perfectly conscious and intelligent, her tongue was clean, no pallor, no cyanosis, and aside from the headache and back-ache she stated she felt perfectly well.

An examination of the blood was made on the 28th of January with the following results:

Hemaglobin 86%.

Red count 4,000,000.

White count 5,800.

Differential white count.

Polynuclear leucocytes, 78%.

Mononuclear leucocytes 21%.

Eosinophiles 1%.

The Widal test was negative.



On account of the low pulse-temperature ratio, the normal respiration and the low white count, the case was thought to be one of typhoid fever. One week later, the Widal was again negative; the white count six thousand and the blood culture failed to show the presence of the typhoid bacillus. An agglutination test for the paratyphoid organisms was then made and found to be negative.

From the 28th of January until the 25th of March, covering a period of eight weeks, repeated examinations were made of the blood; agglutination tests were frequently carried out, bacteriological examinations and cultures were made from the urine, the blood and sputum, stained specimens of the blood were examined for malarial parasites and physical examinations were made almost daily by a number of observers. No phenomena of diagnostic value could be discovered. The patient continued apparently well, was mentally bright, had a fairly good appetite and presented no abnormal symptoms except the temperature which persisted, with slight fluctuations at approximately  $102^{\circ}$ - $103^{\circ}$ . The pulse rarely exceeded 100 and was more commonly beating at the rate of eighty per minute.

The respiratory rate remained approximately the same, from twenty to twenty-four per minute. (For details of pulse, temperature and respiration, see Charts I and II.)

About the twenty-fifth of March, the patient for the first time developed a slight cough and, a week later, fine crepitant rales could be heard over scattered portions of the left lung. A radiographic examination at this time seemed to indicate more or less diffuse infiltration in both lungs and about the third of April, diffuse fine rales could be heard over scattered portions of both lungs. There was no dullness on percussion and, outside of an apparent exaggeration of the respiratory sounds over the entire chest, no other physical signs could be elicited. Failure of nutrition now became quite evident, the cough persistent and accompanied by expectoration of a small amount of mucous. No tubercle bacilli have been demonstrated in the sputum up to the present time.

I believe this case to be one of acute miliary tuberculosis with late pulmonary manifestations. I base this opinion upon the recent results of a physical examination of the chest, the X-ray findings and the fact that we have been able to exclude typhoid

fever and sepsis together with a large number of other conditions capable of producing such a long-lasting fever.\*

For purposes of clinical consideration we can conveniently divide the cryptogenic fevers of long duration into two groups:

*Group I. Physical signs entirely absent.*

*Group II. Physical signs obscure or latent.*

There are many cases of fever of short duration, seven days or less, that might be classified under one or the other of these groups, but it is not my intention to consider fevers of short duration in the present paper. It will, therefore, be understood that only febrile conditions having a duration of seven days or more will be mentioned.

#### GROUP I. PHYSICAL SIGNS ENTIRELY ABSENT.

The vast majority of the cases in this group are due to three infections as will be seen in the following table:

Typhoid Fever,	} 85 per cent.
Tuberculosis,	
Influenza,	
Septicemia,	} 15 per cent.
Malaria,	
Paratyphoid Fever,	
Cerebro-spinal Fever,	
Nervous Fever,	
Malta Fever,	

*Typhoid Fever* is by far the most frequent and most important of the fevers lasting more than a week, unaccompanied by physical signs, that are met with in the United States. Physicians are so accustomed to depend upon certain common manifestations of this disease, such as the typical temperature curve, relatively slow pulse rate, abdominal distention, rose spots, etc., in making a diagnosis, that their attention is frequently directed from the true nature of the trouble by the absence of these objective and subjective conditions. We must constantly bear in mind that typhoid fever as seen at the bedside is quite different from the typhoid fever of the text book and that, not infrequently this disease will run its entire course

\*Two weeks after this paper was read before the Homœopathic Medical Society of New York City, I received a communication from the physician in charge of this patient stating that she had died a few days previously with all the evidences of acute military tuberculosis.

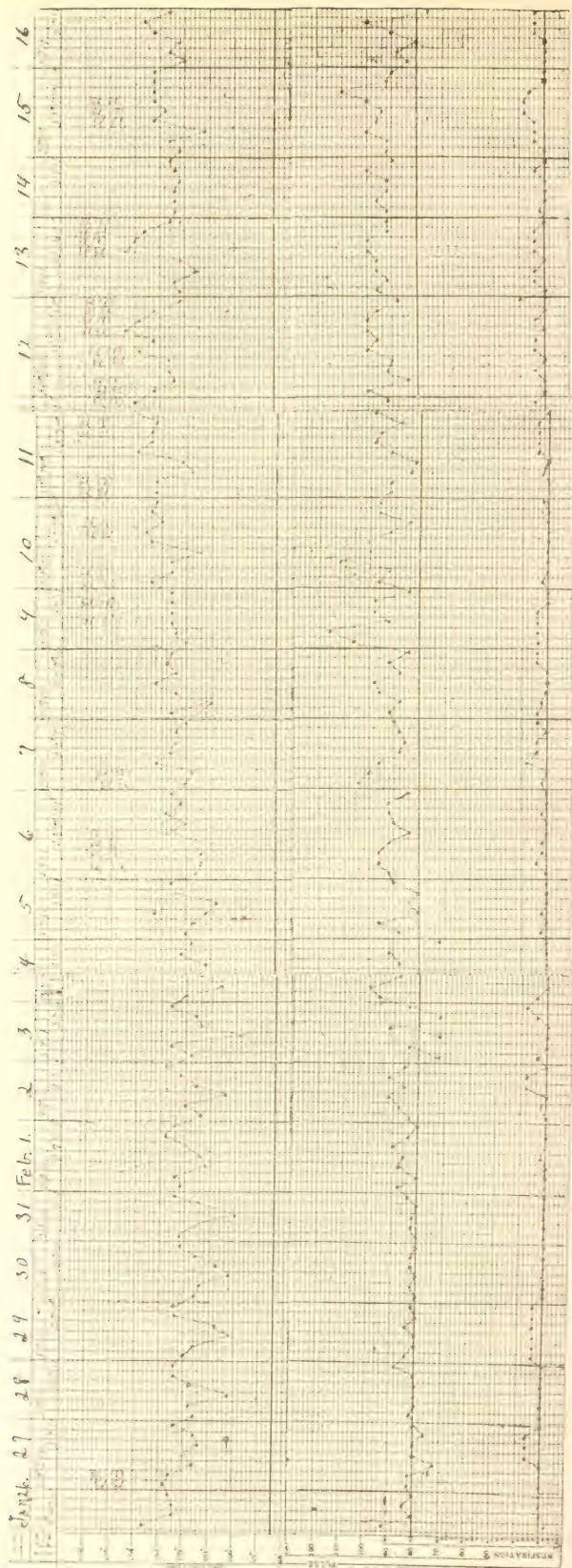
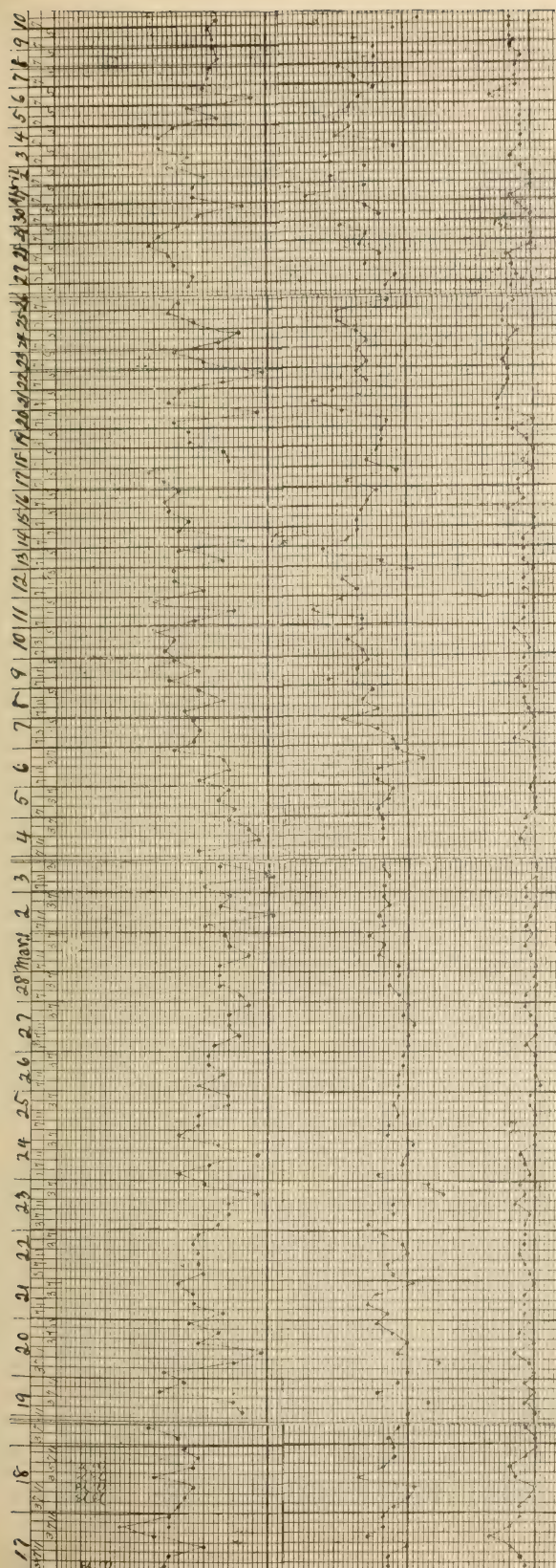


CHART I. Showing the temperature, pulse and respiration curve from above downward, of Sophie K. Note the persistently high range of temperature over a period of ten weeks with a relatively slow pulse rate, gradually rising after the sixth week. The practically normal respiratory rate for the first six weeks is also of interest.





without giving rise to any signs or symptoms of positive diagnostic value.

The laboratory investigation of cases of this character is of the utmost importance. The almost conclusive evidence presented by a positive Widal test is, of course, familiar to you all. We should not forget, however, that this test is usually negative during the first week or ten days and may remain negative throughout the entire active course of the disease, appearing only when convalescence is well established. The blood culture as a means of early diagnosis is of still more importance than the Widal test. By modern methods, positive cultures can usually be obtained during the first week. After the second week, the Widal test is more likely to be positive than the blood culture. The leucocyte count is of great value in the recognition of typhoid fever, as it helps us quite early to exclude many conditions that closely simulate typhoid in their clinical manifestations. It is rare that the white cells in an uncomplicated case of typhoid fever exceed seven thousand, and the average count is between four and six thousand.

*Tuberculosis* ranks next to typhoid fever as an etiologic factor in long continued fevers without physical signs. Acute miliary tuberculosis presents difficulties in diagnosis that may require several weeks to overcome and often the disease is only recognized on the post-mortem table. Unfortunately we have no serum reaction to guide us as in the case of typhoid fever and in many instances the demonstration of the tubercle bacillus in the blood or in the excretions of the body is an exceedingly difficult matter. Sooner or later, physical signs of localized processes may manifest themselves in the lungs, kidneys or other structures, but such localization may only appear after several weeks have elapsed.

We can usually suspect the existence of miliary tuberculosis when, in a patient otherwise free from definite symptoms, we find a marked pyrexia with decided fluctuations in the temperature curve, a relatively rapid pulse, rapid respirations, a low leucocyte count and a negative blood culture and Widal test. In such cases every effort should be made to clinch the diagnosis by demonstrating the presence of tubercle bacillus in the blood, urine, feces or sputum.

*Influenza*, probably the most common cause of fevers of five or six days' duration in which physical signs are absent, occasionally gives rise to a febrile temperature of longer dura-

tion. In the majority of such instances, the prolongation of the fever of influenza is due to some complication, either bronchial, pulmonary or meningeal and physical signs usually appear after a short period. The diagnosis is made somewhat confusing by the fact that a simple infection by the bacillus of influenza gives rise to a low white count very similar to typhoid fever. When mixed infection takes place, however, a high leucocyte count is the rule. The demonstration of the bacillus of influenza in the blood is always difficult and the diagnosis must be made by excluding other bacterial infections and by the comparatively short duration of the disease.

Of the remaining conditions that may occasionally give rise to long-continued fever without physical signs, time permits me to make but short mention.

*Septicemia*: especially after child-birth, or after operation or wounds, is frequently an unrecognized cause of cryptogenic fever. The condition should be strongly suspected in all women developing fever during the puerperium and in all patients presenting wounds on the skin even though the wound may not present any evidence of pain, tenderness or swelling.

*Malarial Fever*: while usually markedly intermittent in its temperate range, occasionally will present a more or less continuous fever. A leucopenia is the rule in these cases and a positive diagnosis can be made by the discovery of the parasites in the blood.

*Cerebro-spinal fever* may occasionally give rise to no diagnostic clinical signs or symptoms after several days or even weeks. Even though the ordinary sign of meningeal irritation may be absent, persistent headache with pains in the back or limbs, typhoid fever being excluded by a negative Widal test and by the presense of an increased number of leucocytes, should lead to a spinal puncture and an attempt to identify the specific organism in the cerebro-spinal fluid.

*Paratyphoid fever* is less likely to give rise to diagnostic symptoms than typhoid fever and should always be suspected when the Widal test is feeble or absent. The agglutination of the paratyphoid fever bacillus by the serum of the patient establishes the diagnosis.

*Nervous Fever*: While one naturally hesitates to attribute a persistent febrile rise to a purely functional nervous disturbance, there are excellent reasons for believing that fevers of this origin undoubtedly exist. Personally, I believe, that many



of the so-called nervous fevers are, in fact, cases of latent tuberculosis. This explanation does not hold good in all instances, however. The subject of nervous fever is usually a hysterical woman whose abnormal nervous state manifests itself not only by a febrile rise but also by anorexia, vomiting, convulsions and other hysterical phenomena. Not infrequently patients of this type will imitate closely some organic disease that has occurred in a relative or friend with whom they have been intimately associated. The diagnosis must be made by excluding organic causes and by taking into consideration the general hysterical temperament of the patient.

#### GROUP II. PHYSICAL SIGNS OBSCURE OR LATENT.

Sepsis and tuberculosis make up ninety per cent. of the cases included under this group. The remaining ten per cent. may arise from a large variety of causes:

Sepsis,	} 90 per cent.
Tuberculosis,	
Syphilis,	} 10 per cent.
Leukemia,	
Pernicious anaemia,	
Cancer,	
Intestinal parasites,	
Rheumatism,	

*Sepsis* in one of its numerous forms, deserves first consideration in cases coming under this group. Septic infection in superficial organs and structures usually manifests itself quite promptly by localizing symptoms of positive diagnostic value. Involvement of deeper organs and tissues, such as the blood, the intestines, the gall bladder, the pelvis of the kidney, the endocardium, the pancreas and the spinal meninges, may fail to give rise to manifestations that will attract the attention of the superficial observer and, in fact, may even elude the observation of the most expert.

I shall allude briefly to a few septic conditions that are worthy of special attention.

*Septic or Malignant Endocarditis*: This condition is frequently mistaken for typhoid fever and, in those instances in which the cardiac signs are latent, the differential diagnosis may be extremely difficult. As a rule, however, there is some

cardiac distress, associated with oppression and shortness of breath and, usually, we detect a muffling of the cardiac sounds or perhaps an actual murmur. The leucocyte count is high and blood cultures will frequently reveal the presence of one of the pus-producing organisms.

*Cholecystitis, peri-gastritis*, the result of an unrecognized gastric ulcer, and *sub-phrenic abscess*, are forms of sepsis that may be overlooked unless careful and repeated examinations are made of the upper right quadrant of the abdomen. The presence of tenderness, however slight, in this region, accompanied by a high leucocyte count and a suggestive past history should awaken in our minds a strong suggestion of one or the other of these conditions.

*Pus*, in the pelvis of the kidney or in the urinary bladder, especially in old men, is not infrequently overlooked as an etiological factor in febrile conditions. The examination of the urine by microscopic and bacteriological methods will usually clear up the nature of these cases.

*Pyorrhoea alveolaris* is quite capable of producing long continued and marked pyrexia. At times this pyrexia may be associated with profound anemia, so much so that these cases are occasionally mistaken for pernicious anaemia. A careful examination of the mouth and of the tonsils should therefore never be omitted in cases of obscure fever.

*Fever following surgical operations* is not infrequently met with, and both the surgeon and the internist should not overlook the fact that however confident the surgeon may be of his aseptic technique, the wound always constitutes a suspicious physical sign. In all cases of fever following operation that are of more or less transitory nature, and in which no other satisfactory explanation can be found, the wound should be carefully examined and opened if necessary. A rising leucocyte count would emphasize the importance of such an examination. Not infrequently in the blood stained serum from such wounds an abundant growth of septic organisms may be obtained.

In all cases of septic origin marked fluctuations of temperature, occasional rigors, relatively rapid pulse rate and a high leucocyte count are to be expected. Any or all of these usual conditions, however, may be absent and yet the pyrexia be of septic origin.

*Localized Tuberculosis* ranks next to sepsis as the common-

est cause of long lasting fever with obscure physical signs. Physicians are too prone to exclude tuberculosis as a cause of continued fever if the results of a physical examination of the lungs are negative, notwithstanding the fact that tuberculous processes not infrequently exist in the lung even though no physical signs can be elicited.

It is not sufficient in these cases to be content with an examination of the lungs alone, but the possibility of tuberculosis of the peritoneum, lymphatic glands, the kidney, the suprarenals, the fallopian tubes and the spine should be thought of. A history of an active tuberculosis in the past, a relatively high lymphocyte count, positive Von Pirquet test and, where conditions permit, the use of the subcutaneous tuberculin test, may help to clear up the nature of the case before physical signs can be obtained. An examination by the X-rays may also give us valuable information otherwise unobtainable.

*Syphilis* either in the secondary or tertiary stages may occasionally give rise to a long continued fever even when obvious manifestations of the disease are absent. Here, again, the history of the case, the presence of old syphilitic scars on the skin, enlarged lymphatic glands and the Wassermann test, will aid us in the diagnosis.

*Intestinal parasites*, especially infection by the trichina spiralis or by the hook worm, may give rise to febrile rise of temperature. Trichiniasis, is especially likely to be confused with typhoid fever owing to the symptomatic similarity of the two diseases. The differential diagnosis can usually be made by finding tender spots in the muscles of the calves of the leg, together with a marked increase in the percentage of eosinophiles in the blood.

Cancer, pernicious anaemia and leukemia rarely cause any difficulty in differential diagnosis after a short period has elapsed provided careful physical laboratory examinations are made.

Subjects of *acute rheumatism* will frequently develop a febrile rise of temperature without any arthritic manifestations. In many of these cases there is probably an involvement of one of the serous membranes either of the pleura or peritoneum or the endocardium. Within a comparatively short time, as a rule, localizing signs can be found in one or the other of these structures.

In this brief review of the conditions that may give rise to fevers of obscure origin, no attempt has been made to give a



complete list of all the possible diseases that must be taken into consideration. I have only endeavored to present the more common pathological conditions that must be borne in mind in arriving at a correct diagnosis and which may serve as a practical working basis for arriving at a correct opinion.

#### SUMMARY.

In closing permit me to present a brief summary of the most important facts:

I. Typhoid fever, tuberculosis and sepsis are the cause of approximately 90% of long continued fevers presenting few or no physical signs.

II. Of these three, typhoid fever is usually the most readily recognized, provided proper pathological tests are made, while tuberculosis is often the most difficult to recognize, on account of the absence of any characteristic blood findings in this disease and also because of the difficulty in many instances of demonstrating the presence of the tubercle bacillus.

III. Careful physical, microscopic and bacteriological examinations, if persisted in, will usually enable us to arrive at a correct opinion as to the etiological factor in all cases of cryptogenic fever.

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#### THERAPEUTICS OF THE NOSE.

BY

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(Read before the meeting of the American Homœopathic O., O. and L. Society, Chicago, 1913.)

It should be a source of intense gratification to every homœopathic physician that, besides the usual surgical methods, topical applications, sanatoria, etc., he has a system of therapeutics based on a law of symptomsimilarity, by which he is enabled to scientifically prescribe and effect cures more quickly and permanently than is possible for those who never investigate, but constantly attempt to belittle, homœopathy.

In the paper which I have the honor and pleasure to present to you, I shall have little which has the odor of newness surrounding it, but which nevertheless never loses its flavor and is always wholesome and worthy of our notice. Besides that

which is truly homœopathic the therapeutics of the nose would not be complete were I to ignore the means at hand for the proper toilet of the mucous membrane with all of the physical therapeutics which we have at our command; each of which may at times be of decided value to him who has the best welfare of his patient at heart.

Homœopathic prescribing never contemplates the application of certain remedies to other certain named diseased conditions. In giving herein some arbitrary names followed by remedies which are likely to find a place in their cure, I do not desire to be understood to mean that these are specifically indicated for the cure of the diseases named. They are merely intended to lead the way to the selection of a remedy by the careful comparison of individual symptoms as found, with the recorded symptoms of the proven remedy. In no other manner can the exact homœopathic remedy be found.

*Nasal Catarrh* commands the attention of a large proportion of the population of this country, whether from the varying and sudden temperature changes to which we are subject or the irritating alkali dust of some sections. Whatever will tend to the alleviation of this condition when presented for our consideration will be most welcome to both patient and doctor.

*Catarrhal Remedies.* As a list of remedies which are frequently found to be of service in catarrhal conditions of the nose, the following are well to bear in mind: Acon, ars., aurum, bell., brom., calc., eupatorium perfoliatum, euphrasis, graphites, hepar, kali b., kali iod., lach., lyc., mercurius, natrum mur., nux vom., puls., rhus tox., selen., sepia, silicea, spigelia, squills, and sulph.

The nose was intended by nature to be self cleansing, but, living under conditions far removed from nature, we are justified in assisting in the cleansing process and we bring to our aid some bland, alkaline solution, to cleanse the mucous membrane and an oily spray to lubricate the same parts for a while. Well suited to the purpose is a normal salt solution followed by a plain fluid alboline. A clean mucous membrane tends to recovery and should be obtained. A restoration of the normal gland supply is best attained by some remedy selected by an analysis of the symptoms peculiar to the patient at hand and it is surprising what marked changes will follow the application of a remedy really homœopathic to the patient. Do not fancy that because you are giving your patient remedies from your

case of drugs that you are treating the patient homœopathically, be it low or high potency, unless you have been careful to select it by the observance of the law of similars. A lack of appreciation of this fact has done much to discredit homœopathy as many have said that they have tried their homœopathic remedies without having results and have therefore taken to other methods; whereas they had not used the real similar at all owing to careless study of the symptoms and modalities of the case.

In catarrhal colds we have a number of symptoms which are to be reckoned with in trying to effect a cure. One of the first is:

*Dryness of the Nose.* When this is combined with a chilliness due to an exposure, camphor, given in drop doses of the tincture, three or four doses at intervals of fifteen minutes or so, will very often abort a cold. If the exposure has been to cold winds, aconite will be likely to be the remedy and the 6th potency will act beautifully. Other remedies having dryness predominant are: Ars., bar. c., bell., berb., bry., calcarea, carb. veg., caust., cham., chel., dig., graph., hyos., iod., kali bi., kali c., lycopod., mang., mercurius, nat. mur., nux. m., nux. vom., petr., phos., psor., rhus tox., rumex, sambucus, senega, sepia, silicea, spongia, sticta, sulphur.

*Sneezing.* When this is a marked symptom in connection with the rhinitis we are attempting to relieve, compare the following: Acon. all. c., amm. m., arg. n., arsen., arum, badiaga, bar. c., bell., bryo., calcarea, caps., carb. an., carb. veg., caust., china., cina., dulc., euphrasia, eupator, perf., graph., iod., kali bi., kali iod., lach., lycop., merc., nat. c., nat. mur., nux. vom., puls., rhus tox., sabadilla, sanguinaria, sepia, sil., spongia, squills, staph., and sulphur.

It may be of assistance to those who are anxious to cure their nose diseases with a remedy to have the subjoined list of remedies and their application.

*Aconite.* When a cold is contracted from exposure to the cold winds of winter, aconite is valuable when given during the first stage, when the nares are hot and dry, and a sensation of chilliness is present.

*Arsenic.* Where there is an excoriating discharge from the nose, which is thin. The patient feels worse when near the fire yet is chilled if he goes out of doors. Constant sneezing which does not relieve. Worse after midnight usually.



*Allium Cepa.* There is an excoriating discharge here also, but the eye discharge is bland, which will serve to differentiate. Patient is worse when entering a warm room.

*Mercurius.* This causes excoriation of the lip, but it is thicker than the discharge of arsenicum. Aggravation at night.

*Alumina.* This is indicated when there is a chronic nasal discharge, internal soreness of the nose and a tendency to slight cracks at the tip, causing soreness to the touch. Patient is usually constipated.

*Antipyrene.* Thin, watery, irritating discharge from the nose and eyes. Long continued sneezing. Intense itching and burning in palate extending to nose, ears and eyes.

*Antimonium Crud.* Indicated where we find a nasal discharge with a tendency to crusting of the nostrils coupled with an eruption around the nose and mouth.

*Arun Tri.* Where there is an excoriating discharge from the nose with complete obstruction and marked soreness and burning of the nose.

*Aurum.* This remedy is chiefly indicated in chronic nasal conditions. The periosteum is affected with consequent soreness on pressure. Caries. Ulceration, Fetid discharge.

*Belladonna.* Sudden redness and burning at the tip of the nose. Internally there is dryness and tickling which is apt to provoke prolonged fits of sneezing. Very sensitive to all odors. Smell of tobacco is intolerable. Patient has sensation of the odor of fish brine in nose.

*Bryonia.* Useful for catarrhs during sudden changes in the weather from warm to cold. First stage dryness of the nose. Later the discharge may be thick with pain over the eyes, aggravated by every movement in walking.

*Bromine.* There is a pressure at the root of the nose and the watery discharge is excoriating. Internal soreness.

*Ammon. Carb.* When the nasal obstruction is mostly at night. In children they awaken and sit up crying for breath.

*Ammon. Mur.* Here the nose is obstructed and there is an acrid discharge and there is sometimes a peculiar sensation of cold between the shoulders.

*Camphor.* This remedy has long had the reputation of being able to abort a cold if it is used at once upon the advent of the chilliness. The nose feels dry and there is some sneezing.

*Carbo veg.* Nosebleed in old people. Varicose veins on the nose.

*Colchicum.* The odor of cooking causes nausea and disgust for food. A valuable symptom in various conditions.

*Elaps.* Fluent coryza. Frequent nosebleed. Nose stuffed up. There is a distress in the stomach after cold drinks.

*Euphrasia.* The indications are quite the reverse of *allium cepa*, for here we give *euphrasia* for an irritating lachrymation and a bland nasal discharge. Cough and expectoration.

*Ferrum Phos.* Nose dry after taking cold. Patient does not respond after his usual bath but the lips become bluish.

*Gelsemium.* Summer colds. Excoriating nasal discharge with pain extending to the ear. Deafness. Every change gives him cold. Malaise.

*Graphites.* Soreness of the nose with formation of scabs. When there is a crack in the corner of the nares.

*Hamamelis.* Profuse epistaxis with feeling of tightness at bridge of nose.

*Hepar Sulf.* Nose pains as if there was a boil on it. Pain seems to be in the bones. Mercurialism.

*Hydrastis.* An excoriating discharge which seems to be mainly confined to the posterior nares, the irritation running down into the throat. Loss of appetite, constipation.

*Iodine.* When the nasal discharge is fluent and makes the nose sore with headache in the frontal region and at the root of the nose.

*Kali. Bich.* The secretion is tough, stringy and is particularly adherent to the sides of the nasal cavities and to whatever it may touch. Ulcers on the septum look as if they had been punched and are deep. Sensation of dryness. Plugs of mucus form and are difficult to dislodge. Great obstruction of the nose.

*Kali Iod.* The secretion is thin and watery and is profuse. Pains in frontal and ethmoidal sinuses.

*Kali Nit.* It is reported that this has entirely cured a nasal polyp on the right side.

*Lycopodium.* Stuffiness of the nose when it occurs at the time of usual aggravation of the drug, 4 to 8 P. M. Nose dry. Mouth breathing caused by the presence of adenoids.

*Magnesia Mur.* A catarrh accompanied by soreness of the nose with sneezing and watery discharge. Pains in eyes with

feeling as if skull would burst. Better in the fresh air. Constipation.

*Marum Verum.* Polypi. Blows the nose but the obstruction is not removed. Sensation of crawling in the nostrils. Sneezing of nervous origin.

*Mercurius.* Excoriating discharge which is thicker than the arsenic discharge. Often agg. at night.

*Naja Trip.* Stuffiness of the nose with sensation of suffocation. Hay fever.

*Natrum Ars.* Nose stuffed, fluent coryza, pain in the eyes and the balls feel too large.

*Natrum Carb.* Thick yellow discharge from the nose. Sometimes sneezing which is accompanied by thin watery discharge. Agg. from all draughts. Nose obstructed at night.

*Natrum Mur.* Watery discharge from the nose and eyes. Loss of smell and taste. Sensation as if sand was in the eyes. Vesicles around nose and lips.

*Nitric Acid.* Nose ulcerated and sore. Fluent coryza but still obstructed. Post nasal catarrh.

*Nux Vomica.* Sneezing in the morning in bed. Fluent coryza on rising. Scraping in throat. Nose obstructed at night. Agg. in the house; lame, in open air.

*Petroleum.* This is another remedy where we find a tendency to cracks at the margins of the nostrils. Formation of crusts. Post-nasal catarrh with tendency to deafness.

*Phosphorus.* Not likely to be needed in acute cases but when chronic and if the bones are implicated. Soreness to touch. Nose swollen. Caries of nasal bones. Bleeding frequently.

*Pulsatilla.* Nose stuffed up in the evening. Much better while in the open air. Thick yellow mucus in the morning. Yellowish-green discharge from nose. Discharge is bland. Sometimes complicated with facial neuralgia, agg. when warm in bed.

*Rhus Tox.* Nose red and painful at the tip as if it would suppurate. Sore internally. Sneezing particularly at night. Coryza accompanied with aching all over. Colds taken after a hot bath.

*Sabadilla.* Itching and dry sensation high up in the nose. Nostrils obstructed. Violent sneezing shaking the abdomen. Lachrymation after sneezing. Oftentimes indicated in hay fever.



*Sambucus.* Suffocating nasal discharge in children when the child awakens and starts up suddenly gasping for breath.

*Sanguinaria.* Coryza with pressing pain at root of the nose. Alternation of fluent and dry coryza. Loss of smell and taste.

*Silicea.* Usually indicated in chronic forms of nasal catarrh with an offensive discharge. Eustachian tubes apt to be involved. Soreness of nose internally.

*Sulfur.* Nose inflamed and swollen. Itching, with burning sensation. Constant desire to blow though there is no mucus discharge. Sensation as if a cold were coming on. Sneezing, which relieves the head.

*Adenoids.* Adenoids may be considered a disease of the nose as far as the treatment is concerned, for many cases of obstruction of the nose are caused directly by the congestion produced by the presence of adenoids and will disappear promptly as soon as the adenoids are removed.

*Argyrol.* We owe a debt of gratitude to Dr. J. Ivimy Dowl-  
ing for his method of using argyrol in solution in the nose for the relief of inflammation of the sinuses and cells therein. Used in an eight per cent. solution and applied on properly made cotton tampons it has wonderful effects in drawing the pus from the cavities and healing, or permitting nature to heal the diseased membrane.

*Electricity.* A mild current from a high-frequency machine, given by means of a vacuum nasal tube, will assist in making perfect cures in ozena if persisted in.

*Douches.* Alkaline douches, preferably by a post-nasal syringe, are valuable in keeping the mucous membrane clean, without which cures must at least progress slower.

*Oils.* The use of a bland oil to the mucous membrane of the nose is valuable for the lubricating effect it has, thereby preventing the formation of crusts. Should be used after the alkaline douche. Should be used after all forms of intra-nasal surgery until the mucous membrane has been fully reformed.

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THE TREATMENT OF ADENOIDIS.—We are so accustomed to think of operation as the only orthodox treatment for adenoids, that it is refreshing to have the faith that many homœopathists hold in the efficacy of drugs in this condition, reinforced in the *Medical Review* by high French orthodox authority. Drs. Lapeyre, Roos, and Lucas-Champanniere recommend iodine and potassium iodide, given perseveringly in small doses. The homœopathicity of these drugs in many cases of the disease make clear enough the reason for their success.—*The Homœopathic World* (London).

**HYDRASTIS CANADENSIS.**

BY

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(Read before the American Institute of Homœopathy, Denver, 1913.)

PROF. A. O. BLAIR, of blessed memory, former professor of theory and practice in the Cleveland Homœopathic College, was accustomed to say to his classes, "If I had to practice medicine and I were restricted to only one remedy I would select *apis*." For catarrhal disorders of the mucous membrane if I were restricted to only one remedy it would be *hydrastis*. Golden seal is a great Indian remedy for some of the ailments of the mucous membrane as well as the disorders of the digestive tract—and valuable as a general tonic. It was our grandmother's and mother's remedy for us children for canker sore mouth or sore throat. It is particularly and pre-eminently the remedy for catarrh or any mucous membrane whether of the mouth, throat, stomach, intestines, uterus and urethra having a thick yellowish ropy secretion. It is useful in the old, easily tired people, cachectic individuals with great debility, emaciation and prostration. Its action on the liver is marked and especially beneficial in scrofulous constitutions, also valuable in cancer and the pre-cancerous state. It is also valuable in the goitre of puberty, in vaginal leucorrhea, nasal and maxillary sinusitis, and very valuable in colitis.

How many of the old reliable remedies are neglected and others of more recent introduction have displaced them as *phytolacca-decandra*, pre-eminent in glandular swellings, *calendula* in open wounds including primary perineal and cervical lacerations, that have been restored without operations; *plantago major* for earache, frequently arresting the disease and thus sparing a mastoid operation; *hypericum* in nerve injuries, even anticipating post-operative tetanus; *symphytum* in periosteal and bone diseases and neuralgia of the stump; *hamamelis* in various congestions, hemorrhages, varicose veins and hemorrhoids, and *silicea* in scrofulous diseases.

I have knowledge of great invalidism to patients from vaginal and uterine catarrh even when the uterus was displaced, restored to health from the use of *hydrastis* internally and locally. As adjuvant treatment to *hydrastis* in catarrhal and ul-

cerated conditions of the alimentary canal, barley water, made slightly mucilaginous, that is thin barley gruel, and drank freely, has proved highly beneficial. I have knowledge of gastric and duodenal ulcers and catarrhal conditions of the gall bladder and sigmoid flexure of the colon cured by the use of hydrastis and the latter with the addition of the medicated colonic lavage.

I have knowledge of its value both in private and consulting practice in acute and chronic catarrhal gastritis or inactive liver or gall bladder disease.

I have knowledge of its value in apparently moribund conditions especially in gastric and duodenal ulcers and cholangitis.

I have knowledge of its efficacy as a wash in epithelioma of the roof of the mouth with the internal medication of iodide of lime and nitric acid to complete the cure, where the advanced condition of the malignancy was so pronounced as to preclude operative measures.

The preparation which I have found most beneficial has been the aqueous preparation, the dose from five to twenty minims in a half or one ounce of hot water every four hours. The muriate of hydrastis 2x in chronic cases has proved beneficial.

Dr. Humphrey, of Toledo, speaks very highly of the muriate of hydrastine 2x in chronic digestive disorders.

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## THE ANATOMICAL RELATION OF THE SPHENOID AND POSTERIOR ETHMOID CELLS TO THE OPTIC NERVE.

BY

LLOYD H. CLARK, M. D., ROCHESTER, N. Y.

Not long since the eye was considered more of a separate entity than any other organ of the body. However, within the past decade this idea has been entirely upset and we have come to realize what an intimate relationship exists between it and the remotest portion of the human organism.

It has been known for some time that pathological states in the nasal chambers and their adnexa exert a certain harmful influence upon the orbit and its contents. Investigators have now so far progressed that we are able in a limited way to trace certain symptoms which show themselves in the orbital content to their origin in the nose and to diseased nasal sinuses.



Since the sinuses are the principal offenders I shall confine myself wholly to their consideration and since even this covers such an enormous field I shall confine myself still further to a study of the posterior ones (the sphenoid and posterior ethmoid).

The sphenoidal sinuses are two in number situated in the body of the sphenoid bone. They are located in the very center of the head, are very irregular in shape, and separated from each other by a thin bony septum. An orifice, usually oval, opens anteriorly into the superior meatus. Its diameter ranges from  $\frac{1}{2}$  to 4mm. and it may vary greatly in its position between the superior and inferior floors of the sinus. It frequently opens at about the junction of the superior and middle third although this is by no means definite. Loeb says that in the great majority of cases it is located midway between the floor and the roof. The opening is near the septum and occluded from view by the position of the middle turbinate and the posterior ethmoid cell. From the foregoing it is very obvious that the higher the opening the less freely the secretions drain and in disease the greater the possibility of a retardation of the discharges.

The sphenoid cell varies considerably in size. It may be so large as to extend into the greater wings of the sphenoid and into the occipital bone as well or on the other hand may be very small indeed. In three or four cases Tunis has seen this sinus occupying every part of the greater wings as well as the body of the sphenoid and not infrequently projecting backward into the occipital bone.

There is no relation in size between the two sinuses in the same individual. One may be very large and the other very small, both may be of moderate size, or both may be exceedingly small and replaced to a considerable extent by a posterior ethmoid cell.

The walls of the sinus are often very thin. The upper wall or roof is frequently the thinnest and the point of least resistance. This is of the utmost import because of the location in many cases of the optic nerve directly above. The posterior wall may also share this condition and as a result of chronic infection the patient is subjected to the dangers of brain and cavernous sinus involvement.

As to capacity and superficial area there are no definite di-

mensions. Loeb\* has made a wonderful study of this subject and has found that the antero-posterior diameter varies from 2 to 42mm., the supero-inferior from 4 to 38mm., the lateral from 2 to 35mm. The smallest sinus had diameters of 2, 4, and 2mm. The largest diameters of one sinus were 42, 22, and 34mm. The average antero-posterior diameter seems to be 21.5mm., supero-inferior 22.8mm., and lateral 18.4mm. The average cubical capacity is 5.145cc. and the range is from 0.6 to 11.8cc. The average superficial area of the sphenoid sinus is 16.65 q. cm.

The posterior ethmoid sinus is located anteriorly and a little to the outer side of the corresponding sphenoid sinus. This cell also varies in size. It may be very small, or on the other hand may be large and partially or almost wholly displace the sphenoid cell of the same side. It may be single or may be divided by a thin septum into two compartments or even more. The walls are very thin and thus it may be difficult to define the point of least resistance. The outer wall is called the lamina papyracea or paper plate and separates the cells from the orbit. This may be easily perforated. As to dimensions Loeb† gives range antero-posterior 13 to 33mm., supro-inferior 6 to 38mm., lateral 8 to 22mm.; average antero-posterior 22.3mm., supero-inferior 23.3mm., and lateral 14.7mm.

The blood supply is from the sphenopalatine, a branch of the internal maxillary which enters the nasal cavities through the sphenopalatine foramen at the upper and posterior portion of the nasal chambers and gives off external branches.

The venous systems of the eye and the nose are very closely related. According to Gurwitsch the superior ophthalmic vein is the chief venous channel of the orbit. He states that a number of nasal veins empty into it so that as a result there is a very intimate connection between the veins of the nose and those of the eye and its appendages.

As to the presence of lymph channels in the sinuses and optic nerve and orbit there seems to be much diversity of opinion. Tunis says he finds no peculiar distribution of lymph tissue between the sinuses and optic nerve which would predispose to infection of one by inflammation of the other. Reber says:

\*Loeb. The Cubical Capacity and Superficial Area of the Sphenoid.—Annals of Otology, Rhinology and Laryngology, March, 1912.

†Loeb. A Study of the Anatomic Relations of the Optic Nerve to the Accessory Cavities of the Nose.—Annals of Otology, Rhinology and Laryngology, June, 1909.

"As to the presence of lymph spaces and a lymph current in the orbital tissue there is still some doubt."

The relation the optic nerve bears to the sinuses is a very important consideration. It may cross the roof or pass along the lateral wall of the sphenoid sinus. The nerve may be very near the wall or separated to a considerable extent. The amount of tissue which intervenes between the sinus mucous membrane and the optic nerve varies greatly—there may be from less than one mm. up to one cm. or even more. This condition is true of the ethmoid as well.

The optic nerve is generally in relation with the posterior ethmoidal cell at its posterior and external angle at the roof and from here passes outward gradually increasing its distance from these sinuses.

There are a great variety of relations which the sphenoid and ethmoid cells may bear to the optic nerve. This has been worked out by Onodi and is given as follows:

1. There may be a thick layer of bone between the optic nerve and the sulcus so that neither the sphenoidal sinus nor the posterior ethmoidal cells are in relation to the nerve—the bony stratum varying from 8 to 12mm.

2. The ethmoid cells may be in relation to the optic nerve and in fact almost surround it while at the same time the sphenoid sinus is not in relation to the nerve at all.

3. The optic nerve or chiasm may be in relation to its corresponding sphenoidal sinus and also to that of the other side.

4. Both posterior ethmoidal cells and the sphenoid sinus of the one side may be in relation to the corresponding nerve.

5. The sphenoid sinus may be in relation to the optic nerve of its corresponding side while the opposite nerve may be in relation to the posterior ethmoid cells of its side.

The optic chiasm is also rather closely associated. It may be posterior or above the sphenoid and be in close proximity or separated by intervening tissue to a considerable extent.

There has been much discussion and there have been a great many theories advanced as to the route by which infection gains access to the orbit. The three supposed channels are the venous system, the lymph channels, and by direct continuity.

Because of the absence of valves in the veins and because of the very intimate relationship of the venous system of the sinuses and the orbit it is more than possible that infection is frequently conveyed by this means.



Infection through the lymphatic system is at the present time a much mooted question.

The conveyance of the organisms by direct continuity seems to be the most probable theory. The bony wall separating the two structures is very thin. Moreover, holes or defects often exist so that as a result the mucous membranes or adjacent structures of the two cavities are brought in immediate contact.

From the foregoing it is not at all surprising that the optic nerve and the eye are frequently involved in acute sinusitis and to a lesser degree in chronic inflammation of the same structures. It is a fact also that even a slight oedematous condition with nasal symptoms absolutely nil may cause marked eye conditions. Therefore, it behooves us as ophthalmologists to keep the fact continually before us that eye lesions may have their origin in adjacent structures and to make or cause to be made further examinations whenever it is deemed necessary.

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### HAY FEVER.

BY

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(Read before the Germantown Homœopathic Medical Society.)

THE name is a misnomer, as true hay fever does not occur until the fall of the year and is not caused by the pollen of hay but by the pollen of other plants, especially ragweed and goldenrod.

On account of its exciting cause, pollen, pollinosis was suggested as a name, but that seems rather fanciful. Vasomotor rhinitis seems best to express the disease, or hyperæsthetic rhinitis, as it was first called by Sajous.

Bostock, in 1819, was the first to call attention to this condition as a disease entity, and J. Blakeley, in 1873, first discovered by experiments the causal relationship of pollen. Dunbar, of Germany, published in 1903, the results of a very exhaustive series of experiments with the pollen of various plants, proving undoubtedly that spring catarrh, or rose cold, is caused by the pollen of grasses, rye, or roses, naming forty-two plants as having irritating pollen, and that autumnal catarrh, or true hay

fever, is caused by the pollen of ragweed and goldenrod especially, in addition to at least twelve other less known plants. His experiments proved that all hay fever patients were affected by using the plant dust in the eyes or nose, and that it produced symptoms only in those susceptible individuals, and also that immunity can not be produced. Since then, although very anxious to find a germ as a cause, he has not been able to do so.

It would be a sheer waste of time to attempt any historical resume of the many causes assigned to hay fever. Some few are worthy of investigation, however. Dunbar insists on the specificity of the disease, and denies any other possible cause than pollen, and flouts the efficacy of any method of treatment except specific antitoxin (pollantin)—protection of the eyes and nose and mouth from pollen or removal to a locality where pollen does not exist. We notice, though, that he also insists on closed sleeping rooms and avoidance of drafts and wind (pollen carriers) during the day, also complete indoor life (in one room) if turgescence is severe, until relieved. But he does admit hereditary predisposition.

Bishop very strongly supports the uric acid diathesis as a cause. Grayson believes that intestinal toxemia is the cause of many cases. Kyle says that "pollen diseases are not caused by local nasal lesions, but by pollen as an exciting cause and by an idiosyncratic predisposition"; and he recently advanced the theory that the local irritation was caused in many instances by chemical changes in the secretions of the glands of the nasal mucous membrane—hyperacidity. Dr. Schadle, of St. Paul, recently called attention to the possible relationship between hay fever and diseases of the accessory sinuses, especially the antrum of Highmore; and Ballenger believes that the irritation caused by the more or less constant discharge from diseased sinuses is a very common cause of hay fever.

However, the general opinion seems to be that there are three distinct factors necessary for an attack of hay fever.

First.—Constitutional or neurotic. This may be due to uric acid, intestinal toxemia, or it may be a pure neurosis, hereditary or acquired.

Second.—Local morbid changes of the nose or accessory sinuses.

Third.—Pollen of certain plants.

There is no doubt of a hereditary predisposition, quite unexplainable. Severe pertussis in childhood favors the production

of hay fever later. Hay fever is rare in children, occurring most frequently between the ages of twenty and forty and about three times as often in men as in women. It is rare in negroes; is very prevalent in North America, it is found in England, Germany and in France, and is almost unknown in the Arctic regions. It is more prevalent in cities than in the country, is rare in workmen, being found mostly among the neurotic type, or those under a strain. Hay fever sufferers rarely develop tuberculosis.

However, there must be an exciting cause, and that has been proven by Dunbar to be a toxalbumin found in the pollen of certain plants, flowers and grasses. Without pollen—no hay fever.

There are, however, many cases of rhinitis with sneezing which persist the entire year and which have nothing to do with pollen and are not true hay fever.

The disease is so common that the symptoms are unfortunately only too well known. It appears usually about August 16th to 19th, and in many sufferers recurs on exact dates annually. Briefly, it may be described as annual paroxysms of sneezing, accompanied by a severe and prolonged coryza and asthma. Itching in the nose, roof of the mouth and eyes is usually the first symptom; then the sneezing with profuse nasal discharge, becoming ichorous; then turgescence of the nasal mucosa and turbinal bodies; conjunctivitis of varying severity with lachrymation and photophobia; later there is asthma, especially in the older cases. The marked nasal obstruction causes frontal headache, anorexia, Eustachian catarrh, tinnitus. Loss of smell and taste occur, and later insomnia and nervous depression. The asthma is reflex, and is caused by the swelling of the middle turbinate and its possibly attendant polypoid condition and continues even after the hay fever sneezing has subsided.

A local examination of the nostrils during an attack of hay fever discloses a general turgescence of the nasal mucosa and turbinates, the mucous membrane being, however somewhat flabby and paler than is usual in such marked turgescence, and this pallor is more pronounced after repeated attacks; also the existence of sensitive areas on the lower part of the middle turbinate, the anterior end of the middle turbinate, the lateral wall of the nose opposite these parts, and the septum above the tubercle. These sensitive spots are slightly elevated, and on



touching them with a probe a fit of sneezing is caused. These areas are at the terminal ends of the fibres of the nasal branches of the fifth nerve and the sphenopalatine ganglion, and the hypersensitiveness does not just "happen," it must have a definite cause and this is the neurotic element in the disease; they are impossible to explain in any other way.

Treatment divides itself naturally into preventive and curative, and the treatment of attacks, sedative.

In the line of preventive treatment, the first consideration must be to get the nasal cavities into as normal a condition as possible, for while it is undoubtedly true that many people with marked abnormality in the nose do not have hay fever, and that hay fever attacks people with normal nostrils, still, all three factors in the etiology must be considered in the treatment. During the period of quiescence, nasal catarrh should be cleared up, on account of the alterations in the secretions; any polypi removed and usually with them the anterior end of the middle turbinate; deviations of the septum corrected and spurs removed. Sinusitis, either catarrhal or suppurative treated, operated radically if necessary.

Constitutional Treatment.—Cold baths and open air exercises. Salicylates for the correction of the uric acid, if found in excess. The correction of intestinal indigestion and its toxemia. The avoidance of alcohol.

Treatment During an Attack.—First, climatic. Removal to a section of the country free from pollen, such as the Adirondacks, White Mountains, Muskoka Lakes, and some parts of the sea coast. After staying in such places for a number of years in succession some people have been cured.

The homœopathic remedies that have been most successful in the practice of the writer have been: Naphtholene 1x, cepa ars. alb. euphrasia, caust., gelsemium.

Powdered sulphate of quinine insufflated in the nose has helped some cases. An oily solution of menthol, 2 per cent., used after an alkaline spray has been a relief to some. Atropia sulphate 1-150 gr. will generally give temporary relief and to this may be added morph. sulph. 1-16 gr. The asthma of hay fever is especially benefited by the use of cocaine applied locally in the nostrils; but cocaine, while very useful in the office, as it gives rapid relief to the turgescence, should be avoided. Never let your patients have it, or let them know you use it; there is a very grave danger of forming the cocaine

habit; and also the secondary effect of vasomotor paralysis usually aggravates the condition. Catarrh snuffs and hay fever cures are, unfortunately, full of cocaine, but under the new pure food laws, this evil is lessened.

The thorough local use of suprarenal solutions, both in the nose and eyes, first suggested by S. S. Cohen in 1898, and used in strengths 1 to 1,000, down to 1 to 5,000, give the most relief locally. Dark glasses are a decided benefit and if a correction is worn, it should be ground in violet tint or smoked lenses for constant use during an attack.

Pollantin (Dunbar) is a serum antitoxin made by the inoculation of horses with the toxin obtained from the albumenoid body found in the starch particles of pollen granules, and is marketed in fluid or powdered form, and in ointment. It is useless hypodermically and must be used on the mucous membranes affected; the powder is the most stable and reliable. The object of its use is to afford immediate relief and to lessen susceptibility, but in the hands of the writer it has not proven very satisfactory in its results. Dunbar, however, claims 85 per cent. benefit with the serum treatment in the past ten years. It has not proven to be a panacea, and there is real danger of producing anaphylaxis by repeated local applications. The principal objection to the serum treatment is that the predisposing factors are ignored. The removal of local causes and the elimination of reflexes must be a prominent feature of any thorough treatment if one is to expect permanent results.

The elimination of reflexes is accomplished by cauterization of the sensitive areas in the nose.

Trichloracetic or chromic acid may be used, but these are not as easily controlled as the electro-cautery. After using cocaine, the flat surface of the electrode, heated to a cherry red, is applied for an instant to three or four spots at a sitting. This is repeated daily for relief. Caution must be observed to avoid destruction of tissue and so possibly causing a later ozena,—there is no danger of interfering with the sense of smell, as the sensitive areas are not found on the Schneiderian membrane. The object is to destroy the sensibility of the terminal nerve fibrilla. To prevent any adhesions, follow the cautery with some oily application, such as benzoin.

If the treatment is begun several weeks before the date of the expected attack and the treatments given every third day until all of the hyperæsthesia is removed, the attack is often

prevented, or lessened in severity and if repeated several years, a permanent cure is effected.

In 1908, the writer reported a number of cases as cured, and it has been possible to follow up some of these cases, and the cure has been permanent.

There is no claim for originality in this treatment. Sajous, in a monograph in 1882, advocated it strongly, and almost every writer on hay fever mentions the cauterization of the sensitive areas, but they do not emphasize it.

The writer, from personal experience, feels convinced that at least one third of all cases of hay fever can be permanently cured by this method of treatment, and that during attacks, relief can be given more quickly in most cases than by other methods alone.

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#### THE USE OF THE THERAPEUTIC LAMP IN SURGICAL CASES.

BY

J. A. BURNETT, M. D., HARTSHORNE, OKLAHOMA.

THE following quotation from Dr. R. M. Sterrett will serve as an introduction to this article: "That the surgical side of the profession has largely monopolized the established hospitals and charitable institutions will scarcely be questioned, not that the special facilities thus obtained have perfected the art and skill of the operating surgeon." Far be it from the desire of the writer to detract in any way from the glory of modern surgery, or, even if in his power, to deprive this branch of the profession of any facility for advancement, but that therapeutics other than along surgical lines should also advance proportionately so as to render the knife many times unnecessary. Some forms of institutional facilities should be recognized and encouraged by the profession as they are by the laity, who, for want of such facilities under the care of the regular honorable educated physician, are led to try the so-called "Medical Institutes" owned and operated solely for gain by unprincipled quacks.

Appendicitis can often be cured with a therapeutic lamp. Dr. D. W. Eiss reports aborting a case of acute appendicitis with five treatments. Dr. J. R. Sewell reports curing a chronic case of appendicitis. The lamp was applied over the region of



the appendix twice daily for a week, then every day for four weeks. In one week's time the patient felt as well as ever. He could lift his right leg, a thing he had not been able to do for two years. He said riding in a wagon would test the case as it had always given him great pain. So he went out and mounted the first wagon he could find and it did not hurt him in the least.

One physician reports curing a case of appendicitis in one week with six treatments and another case in fourteen days with ten treatments.

I feel safe in saying that the majority of cases of appendicitis in which no foreign substance is in the appendix and no pus has formed, can be cured with the therapeutic lamp and other non-surgical means.

Dr. E. S. Killey reports a chronic inflammation following fracture. The thigh from the knee to the crest of ilium was hard to the touch and a strip of purple in color  $1\frac{1}{2}$  inches wide surrounding the limb. Osteopathic liniments, ointments, etc., had been tried and failed. A complete cure was obtained in twenty days by the use of the therapeutic lamp.

Dr. L. Allen says, "I have found the lamp a sure means of curing adenitis either inflammatory or suppurative." I consider this much better than to remove the glands by surgery. The lymphatic glands under the jaw, arms and in the groins are often enlarged from many causes. These enlargements indicate that there is some disease of the system and the lymphatic system is trying to carry it out. The use of the lamp aids the glands in making a cure while surgery removes the glands and the part of the disease that may be found present in them.

In speaking of some of the uses of the therapeutic lamp, Dr. J. A. Arnold says, "I find it par excellent in treating all wounds even when accompanied by septicemia, blood poison, or erysipelas. It relieves blood poison like magic and no surgeon should be without one in his operating room."

Dr. O. S. Barnum says, "Old-fogy surgeons still exist who oppose the advance of light ray therapy, but no field of work has greater possibilities or is worthy of more conscientious and painstaking care." Dr. F. E. Raiche used the lamp with good results in a case of abscess of a tooth. Dr. H. D. Baldwin reports curing an abscess of the liver with jaundice with the lamp in less than one month. Dr. A. K. P. Harvey reports a case

of bursitis of the knee where the cyst contained six ounces of fluid and in twenty sittings with the lamp it was absorbed.

Cases of goitre have been cured with the lamp in three weeks. In speaking of the therapeutic lamp, Dr. J. W. Light says, "The greatest and best successes I have had have been in treating old chronic and indolent varicose ulcers. Usually two or three treatments on one of these cases will start a healthy granulation and in a very short time the ulcer is healed." The lamp is of great value in various forms of old sores of all descriptions including old sore shins which is well known to be hard to cure by common means. Mastoid operations are dangerous; chronic cases of running ear may develop into a case of mastoiditis.

The following, from Dr. C. G. Fellows regarding the use of the therapeutic lamp in mastoiditis, is very interesting: "I am able to add four more cases of mastoid inflammation to the list where operation was imminent and one case in which the physician was summoned for that work, and felt that it was hardly to be postponed and yet in twelve days the patient was discharged with normal symptoms, as far as pain, tenderness, etc., was concerned and with the saving of time and money in his favor."

Dr. H. E. Coger says, "Exudate and accumulations of pus disappear under the systemic application of light energy." Again he says, "Erosions of the cervix yield to the light treatment." He also states, "Gynecology is a field wherein the therapeutics of light energy have not been fully appreciated in gynecic practice. One reason, doubtless, is that surgical procedure has outstripped all other mode as being the more lucrative to the gynecologist and of greater display as to special skill on his part which does much to bring him prominently before the public eye. It is not always the operation upon the uterus and ovaries that produces the most permanent and beneficial results to the patient." There are various other surgical cases besides the various diseases of women in which the therapeutic lamp is of great value in after-surgical treatment.

In discussing this topic, Dr. J. W. Light has the following to say: "After operations for hysterectomy or removal of the ovaries or appendix where there are remaining adhesions and a great deal of soreness in the abdomen, I find that the light treatment is one of the finest things possible. It seems to put new life into the parts and assist in establishing a good circu-

lation and restores a healthy condition." The lamp does not take the place of surgery, but it does take the place of what many consider surgery. The lamp is not always used alone, but in most cases is used in connection with medicines and other forms of treatment.

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## **Transactions of the Homoeopathic Medical Society of the State of Pennsylvania.**

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### **THE RELATION OF BLOOD PRESSURE TO PULSE RATE IN CROUPOUS PNEUMONIA---ITS CLINICAL VALUE.**

BY

G. MORRIS GOLDEN, M. D., PHILADELPHIA.

FIRST attention was called to this important fact by Gibson in 1908. From observations he concluded that, "A pressure appreciably below the normal in croupous pneumonia is invariably of evil omen, and any considerable fall bodes disaster. When the arterial pressure expressed in millimeters of mercury does not fall below the pulse rate expressed in beats per minute, the fact may be taken as an excellent augury while the converse is equally true."

Gordon, several years later confirmed the observations of Gibson. He states, "In no case was there a fatal result when the blood pressure, expressed in millimeters of mercury was maintained above the pulse rate, expressed in beats per minute. While in only one case did it happen that recovery occurred after the blood pressure was persistently below the pulse rate. It may be one's great fortune sometimes to save a case in which the blood pressure is persistently below the pulse rate, but these cases will be few." These observations have been later studied by Hare, Goodman and others and thoroughly corroborated.

During the past year I have made this observation in fifteen cases of croupous pneumonia. These cases showing various ages and physical conditions, also various sized lesions, degree of toxemia and conditions of important organs as heart, kidneys, liver and stomach.



My observations were made with a Stanton sphygmometer and the auscultatory method used. That is the systolic pressure was read when the first sound reached the ear from beneath the cuff, through the stethoscope placed over the brachial artery. The readings were taken from one to four times a day, but suggests that they be taken frequently and at least twice a day.

In eleven of the cases the outcome corresponded to the rules laid down by Gibson and Gordon. That is, in eight cases, where the blood pressure expressed in millimeters of mercury, was maintained above the pulse rate expressed in beats per minute, there was a favorable outcome. In three cases the blood pressure fell below the pulse rate and remained persistently so. These cases all had a fatal termination. The remaining four cases were of irregular types and did not adhere to the general rules.

Time will not permit me to reproduce the charts of all cases, but will show those that were atypical.

CASE I: Mrs. S.; age fifty; croupous pneumonia involving lower left lobe; severe toxemia; marked abdominal symptoms; typhoid state. Blood pressure persistently below pulse rate from inception of disease and could not be raised by stimulation. Death on twelfth day. (See Chart I.)

CASE II: Male; age forty-six; alcoholic; double croupous pneumonia; symptoms classical. At no time during course of disease was blood pressure below pulse rate. No stimulation required. Recovery. (See Chart II.)

CASE III: Female; colored; age thirty-eight. Double croupous pneumonia: pleurisy with effusion. A critically ill patient. Blood pressure below pulse rate; active stimulation required. As result blood pressure arose above pulse rate, and was maintained. Convalescence slow. Complete recovery. (See Chart III.)

CASE IV: Female; age eighty. Left-sided croupous pneumonia. Typical picture of pneumonia in the aged. Blood pressure in close approximation to pulse rate. Stimulation required. Blood pressure arose above pulse rate, but stimulation had to be continued to maintain it there, as her other physical signs warranted it.

From this presentation of cases, I corroborate the findings of the other observers and I also feel that study of the blood pressure in relation to pulse rate should be made in every case

## GRAPHIC CLINICAL CHART

Dedicated to J. P. Conrad Carroll, M.D.

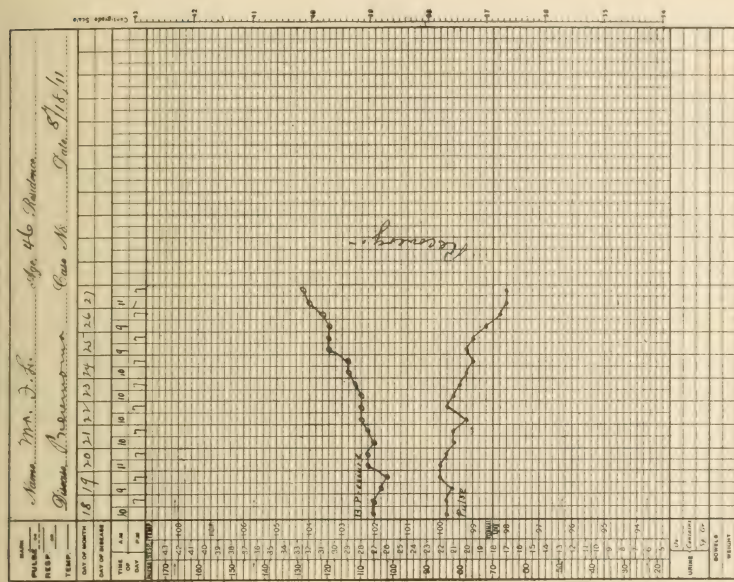
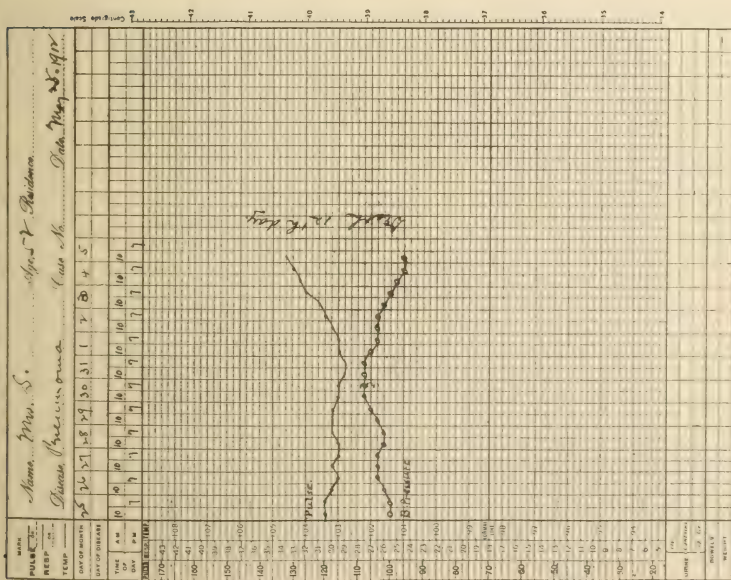


CHART II.

## GRAPHIC CLINICAL CHART.

Dissertation of J. P. Choate, Cambridge, 1866.



## CHART I.

of pneumonia. It is surely a sign of great value, from a prognostic and therapeutic standpoint, and from the latter standpoint as to the condition of the heart and circulatory system.

From a prognostic standpoint, as regards the cardiac and circulatory mechanism, I do not wish you to gain the impression that all other physical and clinical signs, upon which we heretofore relied, should be discarded, but should be considered in conjunction with a study of the relation of the blood pressure to pulse rate. Any factor that is going to help us in the treatment and prognosis of pneumonia, cannot help but be of material value.

All cases that develop in altered or inverse ratio of blood pressure to pulse rate, do not succumb, but if such cases do not respond to stimulation, I feel that the rule holds true with few exceptions. A point which was noted in one case, was the fact that, although the blood pressure was above the pulse rate and patient doing apparently well, there was a very rapid decline in the blood pressure and a rapid increase in the pulse rate, assuming a marked inverse ratio within twenty-four hours and death speedily ensued.

Although this case was doing presumably well, yet it illustrates that type of case in which a sudden calamity takes place out of an apparently satisfactory condition.

In Chart IV, it will be noted that, although the blood pressure was above the pulse rate, stimulation was necessary. This can be explained by the fact that we had a patient of eighty years of age with marked sclerotic processes evident and that a blood pressure of 120 to 130 m.m. was physiologically low for her physical condition.

In relation to its therapeutic value, I feel quite firmly convinced that it is one of the most valuable guides we have, as when to begin stimulation for example:

A patient showing a blood pressure of 120 m.m. and a pulse rate of ninety beats per minute, may be said to be doing well, but if later a blood pressure of 110 m.m. and a pulse rate of 100 beats presents itself, he is not doing so well. A still later observation shows the blood pressure to be 100 m.m. and pulse 100 per minute, we may say he is doing poorly and such a case demands stimulation although the other physical signs of cardiac or circulatory failure may not show themselves at this time. If later, in spite of stimulation the blood pressure con-



## GRAPHIC CLINICAL CHART.

• Demarcado et al. • J. P. Carlos Calvente, M.D.

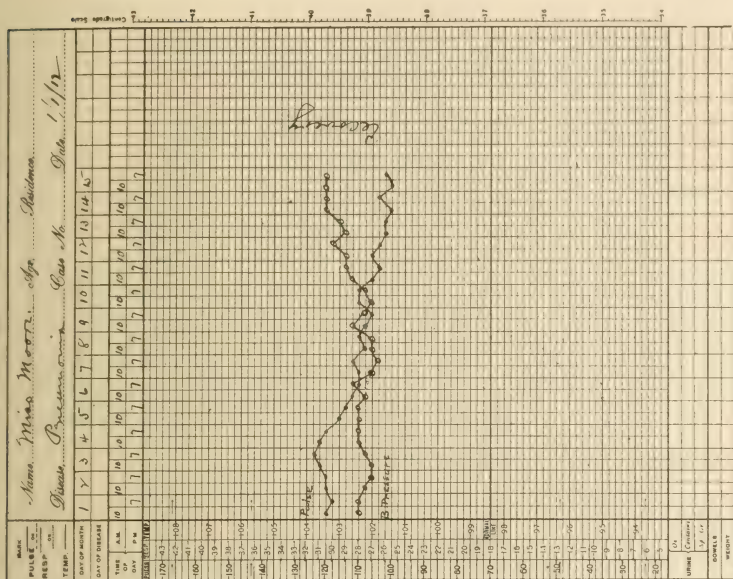
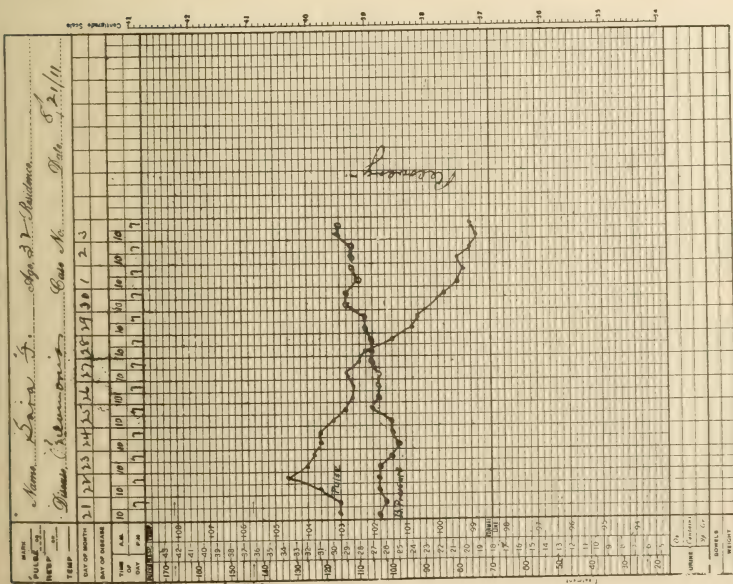


CHART IV.

## GRAPHIC CLINICAL CHART.

Dedicated by J. P. Carlos Gifford, M.D.



### CHART III.

tinues to fall and the pulse rate rise, a fatal termination may be looked for.

By this method of studying the systolic pressure, if we will study the diastolic pressure in conjunction with it, we are able, to a certain degree, to determine whether our failure is cardiac or due to vaso-motor paresis, for this last factor is a potent cause of death in a great percentage of cases of pneumonia. If the heart be at fault, there will be little difference between systolic and diastolic pressure, but, if vascular in its character, the difference between systolic and diastolic pressure will be marked, varying according to the force of the heart. Hence, it will determine to a certain degree the character of stimulant to be resorted to, whether it be one acting purely as a cardiac stimulant, or its greater action upon that organ, or whether it be one acting more markedly upon the circulatory system to overcome the vaso-motor paresis.

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### **SOME REMARKS ON THE ELBOW, WITH SPECIAL REFERENCE TO SUPRACONDYLOID FRACTURES.**

BY

H. M. GAY, M. D., PHILADELPHIA.

Surgeon to the West Philadelphia Homœopathic Hospital.

IN considering any joint from a surgical standpoint, it is absolutely necessary to keep in mind the anatomical relations of its component parts. I therefore take the liberty of refreshing your minds with a few of the more important details concerning the joint we are considering to-day, namely, the elbow, leaving out those that are not of surgical importance.

The flattened out expanded end of the humerus consists of the condyles and epicondyles separated in front by the coronoid fossa and behind by the olecranon fossa. These two depressions almost perforating the bone just above the articular surface which is divided into two portions, the capitellum for articulation with the head of the radius and the trochlea for articulation with the ulna.

Of the two bones of the forearm, the most important at the elbow is the ulna, with its thickened expanded end holding its large articular surface, the greater sigmoid cavity, bounded

in front by the coronoid process and posteriorly by the olecranon tip.

The radius articulates with the capitellum of the humerus and the lesser sigmoid cavity of the ulna. The joint capsule extends anteriorly from a line drawn transversely through the neck of the radius to well above the intercondyloid line on the humerus. Posteriorly the capsule is not quite so extensive, running from the tip of the olecranon to a line bisecting the olecranon fossa.

The muscles of importance in joint injuries are the triceps, arising principally from the shaft of the humerus and inserted into the olecranon process at the point of the elbow, the biceps which crosses the joint to be inserted into the tuberosity of the radius. The mass of flexors and pronators attached to the internal epicondyle and the like mass of extensors and supinators attached to the external epicondyle.

Elbow joint injuries, whether caused by direct or indirect violence, if at all severe, on account of the anatomical configuration of the part, are usually associated with fractures either single or multiple. For instance, the epicondyles may be torn or knocked off, the condyles may be broken off, either by direct violence or associated with dislocation (T or L shaped fractures) we may have epiphyseal separations, the articular processes may be broken off. We may have supracondyloid fractures and it is of them I wish to speak. We may have fracture of the olecranon which is common, of the coronoid process which is rare. During nine years' service at the West Philadelphia General Homœopathic Hospital during which time we have seen several hundred fractures, there has been no fracture of the coronoid process. I believe most fractures associated with backward dislocation of the ulna result in giving way of the internal condyle rather than a fracture of the coronoid process.

Lastly, fractures of the head and neck of the radius. Stimpson remarks, "That our knowledge of this variety of fracture is drawn from about a score of specimens, old and recent, and a few more of less doubtful clinical cases." Leaving out of consideration then these two rare forms of fracture, namely, that of the neck of the radius and the coronoid process, let us see what we have left. (a) Fractures of the olecranon, (b) fractures of the epicondyles, (c) supracondyloid fractures; T and L shaped fractures of the condyles, epiphyseal separations



and fractures of the articular surfaces. I have classified them in this way in consideration of the treatment. Fractures of the olecranon, either open or closed, should be treated in the extended position. Fractures of the epicondyles do not usually involve the joint and may be treated with the internal right angled splint, as this is comfortable and relaxes the muscles sufficiently to allow a union to take place. They are very simple to treat and give a good prognosis.

We have left the other fractures enumerated which are essentially joint fractures and are all best treated by the hyperflexed position.

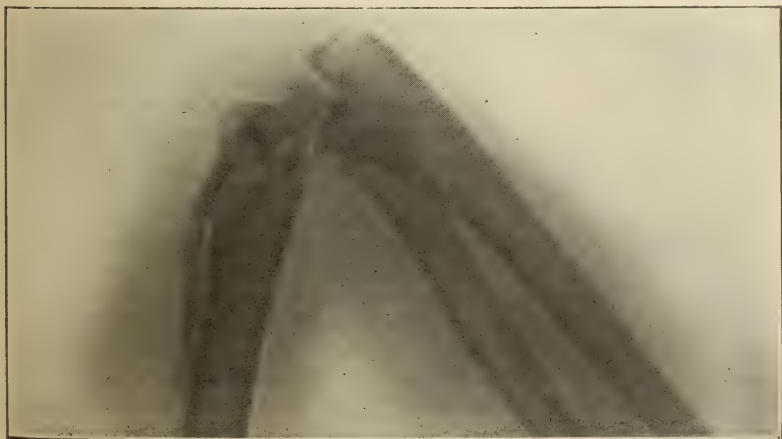
Scudder remarks in his "Fractures and Dislocations" that the hyperflexed position gives the best approximation of the fragments in all elbow joint fractures except fractures of the olecranon. Ashurst in his very valuable scientific monograph on the elbow, draws the same inference. This is especially true of supracondyloid fracture which is extremely common, at least it has proven so in our hospital, and will invariably cause bad results if treated in any other way. Ashurst has proven this experimentally on the cadaver and it may be proven by any observer having access to an X-ray machine. We have tried it over and over again with invariably the same results, namely, approximation in the flexed position, malposition when extended. I am amazed that a thing so easily demonstrated and so simple in its application should have been neglected so long. It simply shows how difficult it is to get away from the established routine, which in this case has nothing to recommend it but age. Most of our textbooks, and not a few of our short articles and papers, recommend extension, counter-extension and the anterior right angled splint for the treatment of supracondyloid fracture. I have only to say that this treatment is uncomfortable, awkward and ineffectual. Ashurst gives several reasons for the persistent tilting forward of the upper fragment in this fracture. Personally, I believe, that it is due entirely to the tension exerted by the triceps upon the olecranon, which pulls the forearm backward, rather than any pull upon the shaft of the humerus.

The chief arguments used against hyperflexion are interference with the blood supply of the arm; and danger of ankylosis, in which case the hyperflexed position would make a useless arm. In answer to these objections, I would say that if the arm is put in a position of greatest comfort, with a care-

fully applied compression dressing, using plenty of cotton and an arm sling for a few days, the oedema will subside enough for the arm to be hyperflexed. It may not be possible to obtain full hyperflexion at once but the arm should be put up as far as it will go without obliteration of the radial pulse. At the next redressing a few days later it will probably be found that the arm may be flexed completely. I will add that if an anterior right angled splint is jammed into the bend of the elbow there will be more interference with the circulation than would be the case with hyperflexion. I speak very feelingly on this point as I have tried both ways.

Concerning the other objection, that if we get bad results the arm should be left in the most useful position, I would say, that our fears are usually groundless. If we are able to get good approximation of the fragments there will not be any great amount of residual callous thrown out. If we do not get good approximation we may expect distortion of the end of the bone, bony ankylosis, gunstock deformity, etc. At the end of four weeks the bandage may be loosened, but the arm still tied rather closely to the neck, at each dressing passive motion should be made and every night the elbow should be shocked with hot and cold water. By six weeks the arm may be left free and light active exercises and massage applied.

I offer a few plates for your inspection which prove the efficacy of the hyperflexed position in supracondyloid fracture.



SUPRACONDYLOID FRACTURE REDUCED BY FORCED FLEXION.



SUPRACONDYLOID FRACTURE BEFORE REDUCTION.



RECOVERY OF SUPRACONDYLOID FRACTURE TREATED BY HYPERFLEXED POSITION.



**BUREAU OF MEDICAL EDUCATION ON LICENSURE—STATE OF  
PENNSYLVANIA. EXAMINATION QUESTIONS—  
JUNE, 1913.**

FIRST SESSION.—MONDAY, JUNE 23, 1913, 2 P. M.—  
PHYSIOLOGY, PATHOLOGY, BACTERIOLOGY.

1. Discuss the evils which may follow the presence of adenoids in the posterior nares.

2. Given a case of pernicious anaemia, describe the microscopic blood picture, contrasting this picture with that of normal blood, and state the effect of this disease upon the normal functions of the blood.

3. Name three most usual causes of death of bone; describe the processes of death of bone and the sequelae of such condition.

4. Given a case of diphtheria, describe the local lesion, give the laboratory methods of verifying your diagnosis and when as a sequela the heart becomes affected, show how the normal functions of this organ are interfered with.

5. Discuss hyaline, granular and fatty casts; (a) as to the local conditions usually present with each variety; (b) as to the impairment of the normal functions of the kidney in each condition.

6. Given an acute case of peritonitis, (a) state how the toxins are absorbed; (b) why the Fowler (sitting) position and enteroclysis are rational procedures.

7. In case of chronic alcoholism state the pathological changes which may take place in the liver and show how these changes interfere with the normal functions of the liver. Contrast pathological changes of advanced syphilis of liver.

8. In carcinoma of the cervix name the most common variety; describe the gross and microscopic appearance and describe the methods and avenues of extension.

9. Describe the lesions, outline the laboratory technique of demonstrating the causes of purulent perforative otitis and show the possible sources of infection and dissemination.

10. In a case of acute anterior poliomyelitis (infantile paralysis) describe the local lesion and show how the normal functions of the cord are disturbed.

SECOND SESSION—TUESDAY, JUNE 24, 1913, 9. A. M.  
DIAGNOSIS, SYMPTOMATOLOGY, MEDICAL JURISPRUDENCE AND  
TOXICOLOGY.

1. Enumerate the symptoms and physical signs in the early stage of acute peritonitis.

2. In syphilis, differentiate:

(a) Chancre from epithelioma.

(b) Secondary skin lesions from exanthamata.

(c) Tertiary skin lesions from other chronic skin diseases.

3. Enumerate the symptoms of catarrhal jaundice (duodeno-cholangitis); name two other diseases of this region that may resemble it, and differentiate them from catarrhal jaundice.

4. State the name and describe the distinctive symptoms of epilepsy resulting from traumatism; how may this form be differentiated from the non-traumatic forms of epilepsy.

5. Enumerate the cardio vascular and the cerebral symptoms of arteriosclerosis and conditions that may follow.

6. Enumerate the symptoms of tetanus: (a) give the etiology, (b) method of invasion, (c) name a toxic condition with which it may be confused and differentiate them.

7. Enumerate the symptoms and describe in detail the physical signs of chronic interstitial pneumonia (fibroid pneumonia) and differentiate it from pulmonary tuberculosis.

8. Enumerate the symptoms of tartar emetic poisoning: (a) name a disease it may resemble and differentiate it, (b) name three antidotes.

9. Enumerate the symptoms of opium poisoning: (a) what are the most favorable conditions for its absorption, (b) differentiate it from apoplexy and uremia.

10. (a) Describe in detail the appearance of an infant born alive at full term; (b) the appearance of an infant dead born at term; (c) the appearance of an infant having died some time before birth, (d) and a method by which it is conclusive that the infant had breathed.

THIRD SESSION—TUESDAY, JUNE 24, 1913, 2 P. M.  
OBSTETRICS, GYNECOLOGY, HYGIENE AND PREVENTIVE MEDICINE.

1. Given a pregnant woman (the first three months) how

would you determine whether she might be suffering from abortion or from extra-uterine pregnancy; in case of abortion how would you treat the case (omit description of operations).

2. If a woman in labor should suddenly develop the symptoms of collapse or shock, name three principal causes in the uterus which may be responsible for her condition. How would you manage the case (omit description of operations).

3. Given a woman with a posterior displaced non-gravid womb, how would you distinguish it from (a) fecal matter in the rectum, (b) a small pelvic tumor. What is the most usual cause of such displacements? How would you prevent it?

4. Name three principal toxemias of pregnancy together with their symptoms. Give the treatment of any one selected.

5. If a woman consults you as to her future labor and places herself under your care up to the time she falls into labor detail the steps you must take in order to secure her safety. (State in full tests that should be made.)

6. When is the induction of premature labor justifiable? Detail its status as related to other procedures in cases of contracted pelves.

7. Enumerate four abdominal enlargements which may be mistaken for advanced pregnancy (seven months or more) and differentiate them from such possible pregnancy.

8. Name the diseases and methods of transmission caused by (a) house fly (b) rat (c) mosquito, (d) bed bug, (e) tsetse fly, (f) wood tick.

9. If an analysis of water revealed the presence of nitrites or nitrates or both why would this indicate its unfitness for drinking purposes. How could it be rendered safe?

10. State articles of food that are advisable in the following diseases: (a) diabetes, (b) tuberculosis, (c) anaemia, with reasons for the recommendations.

FOURTH SESSION—WEDNESDAY, JUNE 25, 1913, 9 A. M.  
SURGERY, ANATOMY.

1. Describe an approved method of performing vaccination; enumerate such complications as may arise and state the reasons for those possible complications.

2. In fracture of the lower end of the radius ("Colles' Fracture") state (a) the usual displacement, (b) the muscles causing same, (c) the method of reduction.



3. State, first, what you consider the favorable conditions in a patient to whom is being administered (a) sulphuric ether, (b) chloroform; second, the unfavorable or alarming conditions that might be present with either drug.

4. Name three forms of bowel obstruction; outline briefly the symptoms that are common to each; outline a surgical operation that may be required in any one form selected.

5. Describe the normal relationship of the bony landmark at the elbow joint; state the alterations that may occur in these landmarks in (a) anterior luxation, (b) posterior luxation, (c) fracture of the olecranon process.

6. In fracture of the neck of the femur, state the usual deformity and the anatomical explanation of the same. Describe an external test line used in diagnosis of some hip joint conditions. Briefly outline two methods of treatment of fracture of the neck of the femur.

7. Name three forms of abscess that may occur in the vicinity of the rectal orifice; state the directions that pus may burrow if left unchecked; briefly outline the surgical treatment of two forms of abscess.

8. State two paths along which infections may reach the kidneys. State the local and constitutional symptoms of pyonephrosis.

9. If called into the country to do an appendectomy; make complete lists (a) those things that you would desire them to furnish at the house of the patient, (b) those things that you would bring with you.

10. Describe methods of treatment of patient who has been subjected to an electrical current of high voltage.

FIFTH SESSION—WEDNESDAY, JUNE 25, 1913, 2 P. M.  
CHEMISTRY.

1. Describe the chemical composition of blood, giving approximately the percentage amount of the various component parts.

2. What is indican? Where is it formed? By what process is it formed? Give a test for its presence in urine.

3. Name the principal waste products of the human body. By what excretory organ is each eliminated?

4. How would you determine chemically whether or not any given stain was due to human blood?

5. Where and in what form do the following chemical elements occur in the human body:

1. Iron.
2. Iodine.
3. Phosphorus.
4. Sulphur.
5. Fluorine.

FIFTH SESSION—WEDNESDAY, JUNE 25, 1913, 2 P. M.

PRACTICE, THERAPEUTICS, MATERIA MEDICA.

1. Outline the management of a case of diphtheria in a child six years old; state the important conditions to be met, with definite methods of meeting those conditions, and give reasons for the use of each remedy selected.

2. Outline the general management of a case of pneumonia in an adult; state three remedies that may be used in this condition, with definite indications for the employment of each.

3. In a case of nephritis, indicate the various conditions that must be considered; state the appropriate remedies for each condition and give definite reasons for the use of each remedy.

4. In acute endocarditis, state the ordinary causes and possible complications, outline the management and give reasons for the employment of the more usual remedies.

5. In acute gastro-intestinal catarrh outline the several indications for treatment, with definite instructions as to remedies and reasons for their use.

#### IMPORTANT NOTE.

Before beginning to answer the above questions, candidates are required to plainly write at top of the first page of their paper, the words, (a) Eclectic, (b) Homœopathic, (c) Old School, according to which school of medicine they represent. In case this is not done, the paper is in danger of being marked by a representative of the Bureau representing one of the other schools, and therefore be incorrectly marked. Any paper not marked as above will be rejected.

## EDITORIAL

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### ARTIFICIAL FEEDING OF INFANTS.

THE artificial feeding of infants is a matter which has received an enormous amount of attention during the past few years. Members of the medical profession, philanthropic societies and Boards of Health have vied with each other in their efforts to educate the laity in methods of artificial feeding for the purpose of reducing the high mortality rate from gastrointestinal and other diseases so frequently fatal to infants that are not fed at the breast.

There is great fear however that many well intentioned practitioners of medicine have been so intent upon securing what might be termed a scientifically ideal method of infant feeding, that they have gotten far away from what is practical and that their activities have resulted in harm rather than good. Those who are desirous of securing practical results in this field should constantly bear in mind the fact that the majority of babies are born in families of limited financial resources. A very large proportion of the mothers of such children have had very few advantages in the way of intellectual training, and their poverty and ignorance make it impossible for them to carry out any system of artificial feeding that makes heavy demands upon their purses, their time or their intelligence.

To advise a mother of this type to use a complex percentage formula, made from milk that retails at twenty cents a quart, is a piece of medical folly that is only too common. Simplicity and economy must be important elements of any method of artificial feeding that is to attain any wide degree of applicability.

It is quite generally recognized by medical practitioners that freedom from pathogenic bacteria is one of the essential conditions, if not the most essential, in an ideal food for infants. There seems to be but two practical methods of securing



economically, bacteria-free food for infants in our large cities, especially in the summer time. One method is to use boiled milk. It has been thought by many that boiled milk was conducive to infantile scurvy and in this country for several years it has been in disfavor with pediatricists on that account. In the European countries, we find that boiled milk is not considered a factor in the production of infantile scurvy, and Breneman states that there is hardly a single modern work in English, German or French, that even mentions boiled milk as a factor in producing rickets. Our own observations lead us to believe that the majority of cases of scurvy and rickets occurring in this country that have been attributed to boiled milk are rather the result of excessive dilution of milk with consequent lack of sufficient nutrition. In any event it is strongly our opinion that in households where cheap grades of milk must be used and where ideal sanitary conditions cannot be obtained in the summer months, it is much wiser to boil the milk, and run the hypothetical risk of producing scurvy, in order to protect the child against the almost inevitable onset of gastro-intestinal infection if raw milk is used.

The second method of obtaining bacteria-free food for infants is to use a food that can be obtained in the form of a dry powder soluble in water. We are well aware that it has been the custom of the so-called authorities on infant feeding to decry proprietary foods that are usually supplied in this form. While it may be admitted that fresh cow's milk obtained and kept under ideal sanitary conditions is a safe and rational food it is just as certainly true that ordinary milk kept and prepared under ordinary conditions during the summer months, is much more likely to be productive of serious gastro-intestinal disturbances than a scientifically prepared proprietary food. We realize that in making this statement we are subjecting ourselves to severe criticism from those who put purely scientific ideals above practical achievements; but, after all, the only interest the physician has in the subject of infant feeding, is to secure that food which will preserve the health and the life of the infants who are under his care.

In the effort to arrive at a conclusion as to the type of food that is best fitted to give these practical results, the lessons of every day experience must have at least equal weight with the too often dogmatic statements of the laboratory worker. After all, Levy stated an important truth when he said "the effect of

scientific artificial feeding on infant mortality will be in inverse proportion to its complexity and in direct proportion to its applicability.”

G. H. W.

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#### TREATMENT OF HAEMORRHAGIC DISEASES WITH HUMAN BLOOD.

DURING the past year a great number of cases have been reported in which human blood has been used for the purpose of checking haemorrhage in patients suffering from the haemorrhagic diathesis. In some instances *whole blood* has been used, while in a larger percentage of cases human blood serum or even horse serum, has been employed. A typical case is that reported by Traver in which a boy of five years of age with a family history of hæmophila, had been bleeding six days from a slight cut of the tongue. The child by this time was pale, the pulse scarcely perceptible and a great many remedies had been employed for checking the haemorrhage. A small amount of blood was obtained from the child's father and placed in the ice box for ten hours. Twenty cubic centimeters of this serum were then injected subcutaneously into the child's buttock. A clot formed within twenty minutes and the bleeding was promptly controlled.

Nicholson has reported a case of melaena neonatorum, developing four days after birth with serious symptoms in which a prolonged therapeutic result was obtained by the injection of twenty cubic centimeters of blood serum. This child, although in a very serious condition, made a complete recovery. A case of Henoch's purpura of severe type occurring in a boy nine years of age is reported by Artson to have been cured in a very short time by the use of four injections of blood serum, averaging about seventy cubic centimeters of the dose.

A very interesting case is cited by Sayer in which a boy of thirteen years of age with a hæmophilic history was struck above the right eyebrow by a pump handle. This bled for two days and the usual local applications were inefficient in controlling the bleeding. Sayer then cleansed the wound thoroughly and making an incision in the third finger of his own hand, he allowed his own blood to drop in the wound. A clot formed at once and the bleeding stopped. Thirty-eight hours later the patient tore the wound open during sleep and

Sayer was able to control the bleeding promptly by the use of his own blood as before.

Stengel in the June issue of *Progressive Medicine* has collected a number of such cases treated by the use of blood serum and indicates in his comment on these cases that equally favorable results have been obtained from the use of *whole blood*, human serum and defibrinated blood.

Horse serum is undoubtedly of considerable value in similar conditions but experience would seem to indicate that it does not possess the same range of therapeutic applicability as do the preparations made directly from the human blood.

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CHAS. A. LEY.

Chairman of Membership Committee,  
First National Bank Building,  
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## GLEANINGS

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ETHYL CHLORIDE IN THE TREATMENT OF CUTANEOUS EPITHELIOMA.—It has recently been stated that the methods mostly in use in the treatment of rodent ulcer are X-ray, radium, zinc ionisation, and solid carbon dioxide. I would like to call attention to another method which has given good results in a few cases, and which possesses the considerable advantage of easy application, and therefore can be used by any practitioner without special training and without special apparatus. Several cases came under my notice and these were reported by Dr. Harold Seidelin. He treated some years ago whilst in Merida, Yucatan, Mexico, two cases of cutaneous epithelioma by means of freezing with ethyl chloride. The reason why he now wishes to publish this experience is that he recently had the opportunity, on the occasion of an expedition for the Liverpool School of Tropical Medicine, of re-examining the patients and confirming the results obtained. A third case of epidermoidal cancer of the nose, which came under his observation in the same place, was so advanced that he did not try the freezing method, but at once proceeded to extirpation which was immediately followed by the application of skin grafts according to the method of Thiersch. This case he likewise re-examined four years after operation, and found the patient, a woman over 80 years of age, in good health, with a smooth, almost invisible scar, without any sign of recurrence.

These cases, together with several others which were microscopically examined in his laboratory, illustrate the fact that carcinomata do occur, and not quite exceptionally, in tropical countries, in spite of what has been said to the contrary. It may be added that all three patients were natives of Yucatan, and that Dr. Seidelin also observed a number of carcinomata in other parts of the body, especially of the uterus. He has previously stated his opinion that the comparatively small frequency of carcinoma in the tropics is more apparent than real. This depends partly on faulty diagnosis and partly on the fact that in many hot countries where the mortality is comparatively high a smaller number of individuals reach the advanced age in which carcinoma is most frequent.

Ethyl chloride was recommended in the treatment of cancer by Howitz, who chiefly used it in cases of carcinoma of the uterus, and to a less extent in some other forms of malignant tumor. In Howitz's second publication two cases of cutaneous epithelioma are described which had been treated by other surgeons according to his method. The method has never come into general use, and certainly no permanent cure could be expected to be obtained in this way in tumors which are not of easy access; in fact, the author of the method regarded its palliative effect in hopeless cases as being of paramount importance.

In superficial forms of cancer, however, conditions are different. The freezing effect can easily penetrate to the deepest parts of a rodent ulcer, and a comparatively exact localization and dosage are possible. Further, the well known tendency of cutaneous epithelioma to remain localized justifies the use of a treatment which lasts for a few weeks; the danger of formation of metastases which in other forms of cancer makes immediate action so imperative is here insignificant. Should the treatment fail to give a satisfactory result, the affection will at any rate not have spread, but, on the contrary, probably have been reduced considerably, and the conditions for another treatment will consequently have improved. There is no inconvenience connected with the treatment; the patient can attend to his business, and need take no other precaution than that of keeping the ulcer covered with a small aseptic dressing. There is very little pain, lasting for a few hours only after each treatment, during the period of reactive hyperæmia. There is but little visible reaction of the immediate surroundings of the ulcer, and I have seen no gangrene, though I have kept the tissue frozen for five minutes or more—a considerably longer time than that recommended by Howitz (1-2 minutes).

The following brief notes will illustrate the cases:

CASE 1.—A man, aged 49 years, from a small town in the interior of Yucatan. The patient knew of no cases of tumors in his family, and his personal history was negative with regard to syphilis and venereal disease. The general state of health was good. Three years ago a small vesicle formed on the pinna of the left ear, and gradually developed into a flattened round ulcer, about 1 cm. in diameter, with red surface and sharp-cut edge. Fragments scraped from the surface showed the structure of an epidermoidal carcinoma. The affection had, by several physicians, been regarded as syphilitic, and the patient had been treated accordingly without any improvement. On October 14th, 1907, treatment was commenced with ethyl chloride, which was sprayed on the ulcer in the ordinary way for about two minutes, the surrounding tissue being protected by cotton-wool. The treatment was repeated on the third day following, and afterwards every second day; the application was gradually prolonged until the tissues were kept white and hard frozen for five minutes each time. A gradual improvement took place and on November 8th it was stated that a small crust was seen which on being removed revealed a small red prominent granulation of 2 to 3 mm. in diameter; the granulation was scraped away with a sharp spoon and the surface touched with chromic acid previous to freezing. When treatment was suspended on November 28th, after about 20 applications, complete healing had taken place.

The patient was examined repeatedly afterwards, and was seen again in January, 1912, that is more than four years since recovery. On each occasion a smooth scar was found, with no sign of reproduction; when examined for the last time the scar was scarcely visible. In this case the sharp spoon and chromic acid were used on one occasion, and the recovery was perhaps accelerated in that way. This, however, seemed doubtful, and in the following case no other therapeutic measures were taken besides the freezing, as improvement progressed steadily and no exuberant granulations were seen.

CASE 2.—A man aged 54 years. This patient, from Merida, observed seven years ago a small ulcer on the left side of the nose; it had increased slowly in size, being now of a somewhat irregular, almost oval shape, about 1 cm. in the largest diameter, and almost reaching the canthus internus of the left eye. No microscopical examination was made in this case, but the aspect seemed typical, and the diagnosis of epithelioma had already been made by several authorities, among others by a well-known surgeon of Paris, who had obtained an apparent recovery by the use of high-frequency current; reproduction had, however, taken place after three months. Treatment with ethyl chloride was commenced as in the first case, the eye being protected by cotton-wool, mackintosh, and flannel. The intervals between treatment were somewhat irregular; the total duration was therefore somewhat longer than in the first case. The issues were kept frozen to begin with for two minutes; later on from six to seven minutes. Complete recovery was obtained after a little over two months, and at the last examination two years later, in June, 1912, the only vestige remaining was a small whitish patch on the otherwise somewhat dark pigmental skin.

It should be clearly understood that he does not advocate this method in the treatment of cancer in general, but only in cases of rodent ulcer and other forms of well-delimited cutaneous carcinoma.—*Harold Seidelein, M. D., Scientific Secretary to the Yellow Fever Bureau, School of Tropical Medicine, Liverpool; Formerly Professor of Pathology and Bacteriology, School of Medicine, Merida, Yucatan, Mexico.*

TOTAL DEATHS FROM TUBERCULOSIS (ALL FORMS).—The total number of deaths from all forms of tuberculosis in the registration area during 1911 was 94,205, the death rate being 158.9 per 100,000—slightly lower than the rates for the preceding years, 160.3 and 160.8 for 1910 and 1909, respectively. The rates for the past three years are considerably lower than the annual averages for the quinquennial periods 1901 to 1905, 192.6; and 1906 to 1910, 168.7. There would appear to be a marked reduction in the death rate from this disease, although the rate for the past three years has remained practically unchanged.

The highest death rates from all forms of tuberculosis shown for the States in the registration area were those of Kentucky, 229.3; Colorado, 218; California, 206.8; Maryland, 203.3; and the lowest rates were those of Utah, 46.8; Michigan, 96; Wisconsin, 103.8; Washington, 106.7, and Montana, 107.1. The high death rate for the group of North Carolina municipalities, 256.8 per 100,000, was due to urban conditions and the large colored population.

The cities of 100,000 population and over in 1910 having the highest death rates from tuberculosis of all forms were Denver, 292.7; Los Angeles, 277.5; Albany, 269.4; Cincinnati, 265.3, and New Orleans, 260.5; while those with the lowest rates were Milwaukee, 106.5; Portland, Ore., 106.8; Spokane, 109.4; Grand Rapids, 110.3, and Scranton, 112.7.

SEASONABLE VARIATION OF THE SYMPTOMATOLOGY OF PULMONARY TUBERCULOSIS.—N. B. Burns, of North Wilmington, Mass., assistant superintendent of the North Reading State Sanatorium, summarizes his obser-



vations in respect to seasonal variations of the symptomatology of pulmonary tuberculosis as follows:

Phthisical patients are apt to lose rapidly in weight and general condition in May, June and the first two weeks in July, which season constitutes an unfavorable and critical period.

Phthisical patients make an extraordinary recovery in weight and general condition in the month of August, which is a surprisingly favorable time of the year.

August, September, January and February are the most propitious months for obtaining successful results in treating pulmonary tuberculosis.

Forced feeding in the unfavorable season seems to have availed very little in the cases studied at North Reading.—*Boston Medical and Surgical Journal*, March 20, 1913.

**DIFFERENTIAL DIAGNOSIS OF ABDOMINAL PAIN.**—Various diseases give rise to abdominal pain in children, and many of these falsely simulate appendicitis, says Finkelstein: (1) Those conditions of pain not abdominal but due to hyperalgesia of the skin reflected from the abdominal organs. (2) Neuralgia of the lumbar nerves due to spinal caries. (3) Fermentative dyspepsia. Moderate pain, but frequently repeated; sensitive to pressure along the colon. Movements follow two or three times a day, are lighter and softer than normal, markedly acid, with a tendency to gaseous formation. Proper diet relieves the condition. (4) Constipation. (5) Neuropathic children frequently suffer from abdominal pains for no apparent cause. These pains come on suddenly and pass off quickly; vomiting is rare. The recti stand out and neuropathic stigmata are common. Suggestive treatment, massage, faradization, etc., usually result in a cure. (6) Small herniæ of the linea alba. It is rarely necessary to treat the hernia. (7) Stenosis of the bowel. In some cases only slight meteorism may be present, vomiting may be absent, and the general condition good; only the attacks of pain point to a serious disease. These cases are all cured after long treatment. The author considers the disease is often due to a passing disturbance, a result of peritoneal adhesions from circumscribed peritoneal tuberculosis. (8) Renal colic. This may give rise to abdominal pain, and repeated examination of the urine will be required sometimes for the purposes of diagnosis.—*Centralblatt f. Kinderheil*, No. XVII, 1912.

**DIFFICULTIES IN THE DIAGNOSIS OF GALL-STONES.**—Bunts (*Cleveland Medical Journal*, March, 1913), states that the diagnostic errors may be reduced to a minimum by careful observations of the following admonitions:

One must have a clear picture of gall-stone attacks. This is probably familiar to every one, and if not is to be found best in any surgical monograph upon the subject.

Never accept a diagnosis of acute indigestion as satisfactory unless the possibility of gall-bladder disease has been considered and definitely eliminated.

Resort to the use of the X-ray by an expert when there is a reasonable doubt as to the existence of renal or ureteral calculi.

Always consider with the greatest care and minutest scrutiny the history of each previous attack when the question of appendicitis is raised, paying particular attention to the time and apparent cause of the attacks, duration, degree of fever, of rigidity, and, after subsidence of the acute pain, the location and persistence of tenderness.

In connection with the history of pain it is interesting to note how many times repeated hypodermics of morphine have been found necessary in gall-stone attacks and how seldom they have been given, or at most repeated, in appendiceal attacks.

Carcinoma of the liver is nearly always a secondary growth and may or may not be associated with gall-bladder disease. When it occurs at the cystic end, there is continuously increasing involvement of the common duct, causing progressive jaundice. It must be remembered, however, that the early appearing jaundice accompanying carcinoma of the gall-bladder or ducts may be instrumental in causing a catarrhal jaundice which will clear up temporarily or to a limited extent under appropriate medical treatment, thus obscuring for a time the real gravity of the case, but in any considerable carcinomatous involvement of the common duct the jaundice is permanent and progressive.

**SO-CALLED HEART MURMURS.**—Steiner writes in reference to the exaggerated importance accorded to cardiac murmurs—with all due deference to the cardinal significance of the latter as symptoms of actual disease. He illustrates the possibility of over-valuation of murmurs by two case histories. The general tendency of all medical examiners is to disqualify a prospective risk whenever a murmur is heard on the ground that no one can assert with certainty that the subject is not the victim of a valvular lesion. The manual of instruction used in such cases states plainly that however faint the murmur, and even after but one examination, the examiner must reject or postpone the applicant. There is only one exaction laid upon him, viz., he must be sure that the sound is of cardiac origin. Thus if the ordinary examination in standing posture is negative, the applicant must throw extra effort on his heart by prescribed exercises and further be examined lying down and with the stethoscope. The examiner may only postpone in the case of young subjects. These commands make it easy for the examiner, but no real service is rendered either to the company or the applicant. Collateral subjects and notably that of the functional capacity of the heart are ignored. When we treat a patient with cardiac trouble we have always in mind the test of efficiency, not the acoustic phenomena. Numerous distinguished clinicians may be quoted to this effect. Murmurs are not necessarily indicative of endocarditis. If truly valvular in origin they may be due either to muscular or nervous action upon the valves. The first case cited occurred in a young man who was well nourished and apparently in florid health. There was no history of disease worth mentioning. During the examination for military service a "cardiac defect" was brought to light. The subject was active all day long on a truck farm, was not fatigued at night, and danced and rode a wheel without effort. The author's examination made after considerable physical exertion yielded a pulse of 69, respiration 9. There was heard, however, over the apex and replacing the first sound,

a long drawn, blowing murmur. This was at once pronounced congenital in origin, and without the least influence on the economies of the heart. Should an applicant like the preceding be rejected outright? Recently the young man broke his leg, as the result of a severe accident; yet his nervous and muscular system showed not the least reaction. The second patient was a German-American, who traveled extensively for a large business house. Always in a state of psychic tension from the exactions of his business, he further sustained great pecuniary losses in the panic of 1907. While sojourning at Kissingen a cardiac murmur was discovered, and was heard by the patient himself with the autostethoscope. The organ itself gave no trouble whatever. The author heard an intensive murmur, propagated from the apex to all the valves. Despite the demands upon the patient's energy the pulse and respiration were but 64 and 16 respectively. There was a transitory emphysema pulmonum, and both this and the murmur are certain to yield to a period of rest. The murmur was doubtless of nervous origin, and technically would rank as initial insufficiency. In both the preceding cases there were no alterations in the cardiac chambers while the second pulmonary sound was normal. It was therefore impossible to estimate the degree of the defect. Compensatory states of the heart could be excluded. In support of his strictures on over-valuation of heart murmurs the author would further cite the statistics of survival of applicants rejected for "cardiac defects" (these naturally including actual lesions with compensation). These take cognizance of survival to 10, 15, 20 and 25 years.—*Blatter f. Vertrauensärzte d. Lebensversicherung.*

A SIGN INDICATIVE OF CHRONIC APPENDICITIS.—Charles D. Aaron (*Jour. A. M. A.*), presents a condition he has found frequently in cases of chronic appendicitis and to which he attributes considerable diagnostic value.

Chronic concealed appendicitis without active inflammation is difficult to diagnosticate. Exploratory operation in these cases frequently reveals an obliterative appendicitis.

In many cases of chronic appendicitis with digestive symptoms the writer has been able to produce a referred pain or distress in the epigastrium, left hypochondrium, umbilical, left inguinal, or precordial region by continuous firm pressure over the appendix; and has found this test very valuable in determining when and when not to recommend operation for chronic appendicitis. All such patients after appendectomy have fully recovered from their digestive trouble. The appendix was usually distorted, adherent or contracted and there was nearly always a history of a previous attack of appendicitis. Frequently the diagnosis of chronic appendicitis is difficult unless the patient suffers from recurrent attacks. Many of these patients suffer from anemia, constipation, loss of flesh and strength and present various digestive and nervous symptoms. The pathologic cause is often found to be a slow proliferation of connective tissue in the walls of the appendix. In many cases the appendix is so contracted that the lumen is partially obliterated. Twisting and bending of the appendix due to a short mesentery may be found. Fibrous thickening in the appendix causes pressure on its nerve endings. The appendix has a rich



nerve connection from the superior mesenteric plexus of the sympathetic with the cardiac, hepatic and gastric plexuses. Many subjective symptoms are thus reflexly produced: asthmatic attacks and tachycardia as well as symptoms of both gastric and intestinal disease.

At operation for chronic appendicitis the appendix may seem normal macroscopically while microscopically the pathologic change can easily be seen. We do not find the appendix distorted in every case but may find distortion, a clubbed appendix, adhesions and even pockets of pus.

McBurney was the first to call attention to the pain on pressure in the right iliac fossa in acute appendicitis. This tender point may also be found in some cases of chronic appendicitis. The referred distress or pain induced by continuous pressure over McBurney's point seems to the writer to be a most valuable sign in arriving at a diagnosis of chronic appendicitis. Several cases are reported illustrating this point.

**TREATMENT OF GLANDULAR TUBERCULOSIS.**—Struthers Stewart (*Journal of Vaccine Therapy*), records his results in the treatment of 54 cases of tuberculosis of the glands of the neck with tuberculin. He always commences with the small dose, 1-200,000 mgm., increasing it gradually till a slight reaction is obtained, and the patient can stand 1,200 mgm. without any reaction. A successful result after six months' treatment must be regarded as a favorable case; with mixed infection the duration of treatment will be much longer. He prefers to deal with each organism separately; the administration of mixed vaccine has many disadvantages. It is impossible to say to which of the organisms the reaction is due, and therefore which should be increased, and there is less risk of development of hypersensitiveness to one or other of the vaccines. On the slightest sign of fluctuation, the glands should be removed; after excision of the glands, a course of tuberculin should be administered. This may be regarded as the ideal treatment. The worst treatment is merely to open a tubercular abscess resulting from the breaking down of a tubercular gland.

**THE RATIONALE OF THE USE OF ADRENALIN IN THE TREATMENT OF ASTHMA.**—McCord, in the *Medical Record* for March 8, 1913, writes on this topic. In the abstracts made by McCord no attempt is made to cover the entire literature, but rather to cite the experimental basis for adrenalin treatment and attempt to correlate clinical results, explained at present by means of far-fetched theories. That adrenalin has found so scant favor at the hands of the general practitioner may be ascribed to the fear of evil secondary effects. Braun warns against the subcutaneous injection of adrenalin, but widespread and extensive clinical experience not only does not bear this out, but indicates that such a fear is groundless. Kirchheim injected daily 12 cc. of the market solution for many weeks into patients with severe infectious diseases. No secondary effects of evil nature were to be noticed. At the time of injection certain unpleasant results have been pointed out as occurring transiently. Severe palpitation of the heart may occur, which leads to a very pronounced, but not accelerated, pulse. A peculiar restlessness may set in which may create the patient's alarm, and at times the face may rapidly become very pale, but all of these pass

rapidly away, and at the same time the respiration becomes easier and softer and the rattling and wheezing sounds cease.

From the results indicated above growing out of the use of adrenalin by both laboratory and clinical workers it seems reasonable to conclude:

1. Adrenalin extends the lumina of contracted bronchioles.
2. This dilatation of the bronchioles is probably the basis for the beneficial action of adrenalin in the treatment of asthma.
3. The dilatation follows subcutaneous, intravenous, and endobronchial administration.
4. The action is transient but very effective in relieving the acute attack. The subcutaneous administration apparently is the most transient.
5. The administration is simple and no injurious results follow as a secondary sequence.

THE PRESENT STATUS OF CANCER RESEARCH.—Cancer is a disease of such frequent occurrence that it destroys about one woman in eight and one man in twelve of all those who reach the age of thirty-five. It is widely distributed throughout the human race, among both civilized and uncivilized peoples, although the view was formerly held that it was more common in the former. This erroneous conception existed because it was not appreciated that cancer is discovered with a frequency that is in direct proportion to the diagnostic acumen of the physicians practicing among a given population, and to the number of autopsies performed. The reputed increase of malignant disease, which has been so widely discussed in the literature, is probably in large part due to increased diagnostic skill, although there is a certain amount of evidence to suggest that a real increase may be taking place.

Cancer is distributed widely, not only among mankind but among the lower animals as well, down to the reptiles. The laws governing its incidence coincide with those which hold for man, and it is most common among old animals, an observation which adequately explains its wider occurrence among domestic creatures, since they attain a greater age than those living in a state of nature.

The mouse has been chosen for investigation, principally because of the facility with which it can be handled and the readiness with which it can be obtained. Hence the fact that our more recent knowledge of cancer depends upon observations on this animal must not be taken as implying that the findings might not hold good for malignant growths in other species, were it convenient to investigate them in the same way. In the mouse the usual site of origin is the female mammary gland, and the clinical course of the disease follows closely that in man. Metastasis is common, taking place usually by the blood stream, or more rarely by the lymphatics, while true infiltrative growth is easily demonstrable.

It has been possible to conduct experiments concerning the hereditary transmission of a tendency to develop spontaneous cancer, and these have led to the discovery that mice whose mothers or grandmothers developed malignant new-growths are themselves more liable to fall victims to the disease than those with a non-cancerous ancestry. The percentage of cases among mice of cancerous heredity was 18.2, while among those with non-cancerous antecedents it was but 8.6. This information may be applied to

man, however, only with the greatest reservation, because in the experiment just mentioned animals with a concentrated cancerous ancestry were selected and bred together, and the tendency in the offspring was accordingly greater than it ever would be in man, except in rare cases and as a result of the most unfortunate coincidence.

Mice may be immunized against the transplantation of cancer by the unsuccessful implantation of mouse tumors or by the inoculation of normal and intact cells of their own species, but the tissues of an animal itself, when re-introduced into its organism, have not the power to confer immunity, nor can a mouse bearing a spontaneous tumor be immunized against inoculation of its growth into another part of the body. This fact is of extreme importance, bearing as it does upon attempt to circumvent metastasis or recurrence. When a tumor graft is implanted into an animal which has been rendered immune, the ingrowth of fibroblasts and blood vessels described in a preceding paragraph does not occur, and the fragment gradually dies from mere inanition; there is nothing to suggest that it is destroyed by any immune forces similar to those with which we are at present acquainted.

Immunity is active, however, only against a graft which is in process of establishing itself in a new host, and it exerts no inimical effect upon a transplanted tumor that has already gained a foothold. It would certainly be even less efficacious against a spontaneous neoplasm; hence, the treatment of malignant new-growths in man by means of tissue emulsions, filtrates, and so forth, has no support from the experimental work so far accomplished in the laboratory. The problem of treatment is to find some substance which will exert a destructive action upon the malignant cell, while at the same time the other cells of the body remain uninjured. It has not been demonstrated beyond discussion that radium is able to exert any selective action upon malignant growths, nor has chemotherapy yet offered anything more than a hint. Von Wassermann has published some suggestive experiments with selenium and tellurium, but he himself was the first to indicate that they represent merely an interesting biological finding. In the domain of immunity nothing has been accomplished, since the existence of anything in the nature of an antibody has never been clearly proved. Surgery, therefore, offers at present the only rational means of combating the disease. The hope of substituting some specific means of treatment for this crude and only too often inefficient procedure is based on the observation that transplanted tumors, and even, in a few instances, spontaneous growths, are known to recede, although there is still no indication of the manner in which this end is brought about. Accordingly, although many of the results of ten years of investigation have been negative, they have at least fully demonstrated the utter hopelessness of temporizing with malignant disease, and the imperative necessity of early and thorough removal.—*William H. Woglom.*—*International Journal of Surgery.*

**RADIUM IN OPHTHALMOLOGY.**—If one brings a sufficient quantity of radium in contact with the closed eye, the temple, the vault of the skull or the occiput, a sensation of light will be produced. The radium rays do



not act on the retina nor visual purple; the rays have no refracting power, so that no image is thrown on the retina; the beta rays, the most active, do not reach the retina, being absorbed by the media of the eye, hence we conclude that the radium emanations act by fluorescence of the refractive media of the eye and by direct irritation of the cortical visual center, producing an increase of visual power. The diseases to which radium can be applied successfully are external of the eyelids, cornea and conjunctiva. It may be applied naked or filtered, but bearing in mind its powerful caustic effect in all cases except epithelioma it should be filtered through tin, lead or aluminum. Rodent ulcers, angiomas and epitheliomas of the lids yield readily. A case of sarcoma of the brow which melted away under treatment is recorded. Trachoma and pterygium are greatly benefited or cured. Lupus of the conjunctiva and severe corneal ulcers offer promising fields of treatment. The analgesic action of radium has been frequently noted, especially in neuralgia.—*Dr. C. Sterling Ryerson.—Ophthalmoscope.*

WILLIAM SPENCER, M. D.

GLAUCOMATOUS TENSION RELIEVED BY ANTERIOR SCLERECTOMY.—The patient, 42 years old, presented herself at the New York Ophthalmic Hospital with acute glaucoma in the left and absolute glaucoma in the right eye.

There was a history of a severe and painful inflammation in both eyes seven years previously, with loss of vision and more or less permanent pain and irritation in the right eye, the left recovering except for a moderate reduction of vision. For four months just preceding her first examination there has been pain and failing vision in the left eye, and for six weeks she had treatment in another public clinic. The examination disclosed in the right eye a condition of absolute glaucoma, and a large sloughing corneal ulcer and an anterior staphyloma. In this eye an iridectomy had been made. In the left eye she had acute glaucoma with the usual signs of insensitive and steamy cornea, dilated pupil, shallow anterior chamber, vascular conjunctiva, puffy lids, and absence of nasal field of vision.

The tension was high. She was able to count fingers to the temporal side at a distance of six feet. It was impossible to make out the details of the fundus. She was admitted to the wards, eserine instilled in the left eye and the right one enucleated.

A few days later, tension still remaining high, it was decided to enter the anterior chamber in an effort to so reduce the tension as to render the eye more favorable for an iridectomy. For this purpose he elected to use a split keratome, and it was accordingly entered well back in the sclera passing through the iritic angle, making as wide an incision as the instrument would allow. Postponing iridectomy, it was found, one week later, that vision was 10-200 and tension normal. In the course of four weeks the vision improved to 20-100, and she still retains this power. Deficient as it is it has enabled her to take up her former occupation. In a recent examination she reported her eye as having been entirely comfortable. It was free of any sign of congestion, the pupil reacted fairly well to light, vision remains 20-100, there was marked glaucomatous cupping

and the field much contracted, although apparently in a state just as arrested by the sclerectomy twenty-one months ago.—*Dr. G. DeWayne Hallett.—The Jour. of Ophthal., Otol. and Laryngol.*

WILLIAM SPENCER, M. D.

**A SARCOMA OF THE CILIARY BODY.**—Professor Fuchs presented a case of intraocular tumor before the Vienna Ophthalmological Society. Because of the clinical appearance he made the diagnosis of an epithelial tumor of the retinal pigment of the iris or ciliary body. The patient was 26 years of age. He first noticed a gradual diminution of sight for ten months previous; at the time of presentation the eye was blind, and for the past two days painful from secondary glaucoma. The peculiarity of the clinical picture was that the tumor presented itself in the pupillary area, and that posteriorly it did not arise from the anterior surface of the iris. The only possibility was of its arising from the posterior surface of the iris or ciliary body. Fuchs excluded sarcoma of the iris because such arise from the anterior surface of this membrane. Melanoma of the iris arises from the posterior surface and has a different color and structure than the case which he presented to the society.

Sarcoma of the ciliary body was excluded because its usual course is to punctate through the root of the iris and anterior chamber. A histological examination of the enucleated eye determined that the tumor instead of being an epithelioma was a sarcoma of the ciliary body. Sarcoma of iris, ciliary body and choroid have definite clinical characteristics which enable the ophthalmologist in the majority of cases to make a correct diagnosis; only those sarcomata of the ciliary body known as ring sarcoma give difficulty of diagnosis because of their growth into the pupil.—*The Jour. of Ophthal., Otol. and Laryngol.*

WILLIAM SPENCER, M. D.

**ABDERHALDEN'S BIOLOGICAL TEST FOR PREGNANCY.**—According to Abderhalden's observations, the development of a placenta causes the appearance of a foreign protein in the mother's blood. The test is based upon the assumption that a protein, foreign to the blood, will induce therein the development of an enzyme, capable of splitting such foreign protein.

Two methods of making the test have been described. The first method depends upon a change in the optical characteristics of the serum after it has been allowed to remain in contact with peptone prepared from placenta or with a preparation of the boiled placenta. Such change is noted with a polariscope. Williams and Pearce (*Surgery, Gynecology, and Obstetrics*, April, 1913), find this method objectionable and have employed another method in a series of tests. They use the technique as recommended by Abderhalden, i. e., the transformation of the protein in the placenta which is recognized by certain color reactions, after dialysis. The method of performing the test is as follows: Fresh placenta free of all soluble protein is added to serum and placed in an animal membrane. This membrane must be permeable to peptones only. The membrane is then placed in a beaker of water, and after 16 to 24 hours the dialysate is tested for peptone or amino-acids. Triketohydrindenhydrat (Ninhydrin)

is used as a reagent and a deep blue color results if the reaction is positive.

In thirty-six cases the test has always been positive in a known pregnancy. They have found, however, that the serum of pregnancy reacts with tissues other than the placenta, and in addition have obtained the reaction in cases of nephritis, tabes and infection, and in some individuals apparently in perfect health. Their latter findings, of course, eliminate the present test as an accurate clinical test of pregnancy. McCord, however, in the same journal basing his observations on 240 tests, concludes that this method of sero-diagnosis, is both reliable and practical.—*Medical Review of Reviews*.

ROENTGEN TREATMENT OF CARCINOMA OF THE UTERUS, BREAST AND OVARIES.—Since 1911 Professor G. Klein (*Munch. med. Woehensch*, No. 17, 1913), with the assistance of Drs. Hirsch and Monheim, has tried the Roentgen treatment of uterine cancer with a new and improved apparatus in twenty-one cases. In twelve of these cases the procedure was resorted to after hysterectomy and in nine for inoperable uterine cancer. Besides these, one case of mammary and five of ovarian cancer were treated by this method. In every instance the favorable influence of the rays upon ovarian carcinoma was unmistakable, as shown by the slower growth and firmer consistence of the tumor. Among the cases of uterine cancer three were considered particularly noteworthy. The first was one of cancer of the cervix, extirpated by Wertheim's method, in which the X-rays were used for the treatment of recurrences in connection with curettage, with prevention of any further return of the disease. In the second case, a malignant adenoma of the cervix, in which the pelvis was filled with the growth, the cancerous mass was converted into a tumor with thick connective tissue walls occupying a much smaller area. In the third case radical operation had been done for cancer of the cervix. An infiltration was left on one side which subsided completely after the use of the rays. Klein urges immediate resort to Roentgen treatment as a prophylactic after radical operation for uterine cancer, for the purpose of destroying any microscopic remnants of the disease. In inoperable cases he advised curettage and cauterization, followed by the use of the X-rays. He also refers to a case of cancer of the breast, in which after amputation nodules recurred which were repeatedly extirpated, the X-rays being used during the intervals. After extirpation of the last nodule, which was shown to have no cancerous elements, no recurrence has taken place within two years. Similar results have been published by others.



## Monthly Retrospect

### OF HOMOEOPATHIC MATERIA MEDICA AND THERAPEUTICS

CONDUCTED BY DR. DONALD MACFARLAN  
PHILADELPHIA

GLEANINGS IN HOMOEOPATHY.—Homœopathic practitioners will be interested to know of statistics of the cases of pneumonia treated in the Royal Infirmary of Edinburgh from 1839 to 1849 (the figures are taken from the late Professor Hughes Bennett): Total number of cases 648, deaths 222, mortality 34.2 per cent. Within the same period, from the year 1844 to 1848, Fleischmann treated in the Homœopathic Hospital at Vienna 284 consecutive cases with only 10 deaths—mortality 3.5 per cent. The difference between a mortality of 34.2 per cent. and 3.5 per cent. is considerable. Can this discrepancy be accounted for simply on the theory that the homœopaths gave Nature a free hand? If this were so, we should expect the 34.2 per cent. mortality to come down to something like the low level of 3.5 per cent. at any rate. In the ten years from 1896 to 1906, when the expectant treatment was in full swing and allopaths had learnt the futility of drugs, 7,868 cases were treated in the various London hospitals (I quote Allbutt's "System of Medicine"), and the mortality was 21.8 per cent. There is a decided drop in the percentage you see—from 34.2 to 21.8. That gives you some idea of the proportion of cases, some 12 or 13 per cent., that used to be conjured into their graves by the medicine-man of the good old days—cases that, if let alone, would have recovered.

Also sixty-one cases of true cholera, were treated at the Homœopathic Hospital, with a total of ten deaths—a mortality of 16.4 per cent. In the other London hospitals the mortality was 51.8 per cent., or more than three times as great. In the Naples epidemic of 1854-5 Dr. Rubini, following the recommendation of Hahnemann himself, who twenty-three years previously had stated that camphor was the true remedy for the first stage of cholera, treated with camphor 225 cases in the Naples infirmary, and in addition 166 soldiers of the Third Swiss Regiment—391 cases in all—without a single death. In the last cholera epidemic in Naples, which was in 1884, Dr. Rubini, then a veteran of eighty-four years, was absent from the town, but the medical men attached to the homœopathic dispensary in Naples treated eighty-three cases, with a mortality of 3.6 per cent.

The highest mortality percentage in these homœopathic statistics is

that of the London Homœopathic Hospital in the 1854 epidemic, viz., 16.4 per cent. Yet how much lower even that is than the allopathic low-water mark of 30 per cent., as given by Osler. Is it not, therefore, abundantly evident that the *vis medicatrix naturæ* is by itself quite inadequate to explain the low mortality that prevails under homœopathic treatment?—*Homœopathic World*, February 1, 1913.

SOME CLINICAL EXPERIENCES EMBRACING TREATMENT. *By Leon Brasol, M. D., St. Petersburg.*—On May 2d, a peasant woman, Martha Y., æt. 22, applied to me and complained of pain when swallowing, and great pain in the lumbar region. The patient's nasal pronunciation and a slight hoarseness in her voice at once attracted my attention. On examination, I found intense redness and ulceration of both tonsils; a partial defect of the uvula; a small suppurative ulcer (about the size of a millet seed) on the hard palate, and a defect of the nasal septum. Ozaena, with a thick, purulent discharge. The cervical, occipital and sub-maxillary glands were enlarged. The other glands were not perceptibly enlarged. There was no cutaneous eruption. The sexual organs were not examined, as the patient would not consent to that, but she declared positively that there was no eruption or ulceration whatever on her sexual organs, nor had there been any. Menstruation in order. Anamnesis was negative, as is mostly the case with peasants, especially the females. Nevertheless, the idea of syphilis forced itself on me. According to the patient's account, she had been in that state for about two months, and was steadily getting worse. In all cases of established or suspected syphilis I usually begin the treatment with mercurius corrosivus in one of the three decimal potencies, and if the sublimate is the individually specific remedy for a given case, the tendency to improvement shows itself from the very first days after administration. Should the first decimal potency of merc. corr. not prove efficacious within a maximum period of fourteen days, I do not persist in giving it, but try other specific remedies.

On May 2d, I prescribed merc. corr. 2x, three times a day, in doses of five drops, and told the patient to come again in a week.

May 9th.—Progressive aggravation both of objective and of subjective symptoms. The pain in swallowing was greater, the pains in the lumbar region were intolerable. On swallowing water, it was rejected through the nose. On examining the patient, I saw that the ulceration had made great progress; all that remained of the uvula was a little stump; the ulceration of the tonsils was deeper and dirtier; the ulcer on the hard palate had increased to the size of half an inch in diameter and presented malignantly suppurating and unclean edges. The ozaena had increased. It was clear that further delay was impossible, for the whole process had assumed a very malignant form. Mercurius corrosivus had proved unfit for the present case, and it was necessary to turn to another specific remedy.

One of the most valuable of such remedies is kali bichromicum. This remedy has a specifically-selective action (1) on the skin, where it causes a cutaneous eruption, principally in the form of pustules and papulae, which are often taken for syphilitic, and likewise of ulcers which leave a

depressed cicatrix on healing; (2) on the mucous membrane of the mouth, nose, respirative and digestive organs, where it causes inflammation with a tendency to suppuration; (3) it has likewise an undoubted tendency to cause a destructive ulceration of the nasal septum, and to bring on various osseous and rheumatoid pains in different parts of the human body.

The similarity between the pathogenetic symptoms of kali bichromicum and the respective symptoms of the case in question, as likewise the clinical observations on the efficacy of kali bichromicum in many cases of syphilis, led me to choose this remedy.

On May 9th I prescribed kali bichromicum 3x, three times a day, five drops to the dose, and told the patient to come again in a week.

May 16th.—Decided improvement in all subjective symptoms; the pains of which the patient chiefly complained, i. e., in the lumbar region, and those felt in swallowing, were considerably less. The objective symptoms were likewise more favorable. The dirty and purulent appearance of the ulcers of the buccal cavity had perceptibly improved; the edges of the ulcer on the hard palate presented a clean, granulating surface. There was still some difficulty experienced in swallowing water, and it was still rejected through the nose, though in a lesser degree. The ozaena had diminished. Prescribed kali bichrom. 4x, five drops three times a day.

May 23d.—Patient still better. No pain in swallowing. Water not rejected through the nose. The discharge of stringy and fetid pus from the nose had almost ceased. The tonsils, the stump of the uvula and the ulcer on the hard palate showed a clean, granulating surface with decided tendency to heal; the circumference of the ulcer on the hard palate had perceptibly diminished to less than half the size. Total cessation of lumbar pains. Voice less hoarse. The patient rejoices at the improvement and of her own accord asks to have the same medicine given her again, to which I seemingly consent. But now, *experimenti causa*, under the form of medicine, pure alcohol is given her, to be taken three times a day, five drops at a time; and she was told to return in a week.

May 30th.—The improvement went on until May 26th, and then the symptoms seemed to grow worse. Again there was uneasiness in swallowing, increased discharge from the nose, and greater hoarseness. There was no perceptible aggravation of the objective symptoms, but neither was there any improvement. The patient was told to continue taking her drops, and to come again in four days.

June 4th.—A decided aggravation both of subjective and in objective symptoms. The pain in swallowing almost as bad as before, and ozaena worse. Again there was suppuration and a dirty deposit on the ulcerated surfaces of the buccal cavity. The stump of the uvula completely destroyed. The ulcer on the hard palate, though not increased in size, was dirty and malignantly purulent in appearance. Prescribed kali bichrom. 4x, three times a day, in doses of five drops.

June 11th.—The patient felt better after the first doses of medicine, and this improvement continued all the week, in full accordance with the results of objective examination, i. e., an improvement and decrease of the ulcerated surfaces, cessation of ozaena, clearance of the voice. Prescribed kali bichrom. 5x, twice a day, five drops to the dose.



June 22d.—Improvement going on steadily. The patient did not complain of anything. Voice clear; the original nasal tone had improved considerably. The ulcer on the hard palate had healed completely, from the circumference to the centre, and now showed a whitish cicatrix. The ulceration of the tonsils was restricted merely to the inner edge of the left tonsil, where one could still see a narrow stripe, not yet healed over, but cleanly granulating; the right tonsil was quite healed. Prescribed alcohol, to be taken twice a day, five drops at a time, and told the patient to come again in case she felt worse.

July 4th.—The improvement went on for a whole week. During the last few days there was some return of the pain in swallowing, and the discharge from the nose reappeared, though without being fetid. The nose was somewhat painful to the touch. An objective examination showed a redness of the pharynx and a dirty puriform deposit on the inner edge of the left tonsil. Prescribed kali bichrom. 5x, twice a day, in doses of five drops.

In the end of July I saw the patient in perfect health. All the local symptoms in the buccal cavity and nasal region had disappeared; the subjective symptoms had ceased completely. It is worth noting, that within the course of the whole treatment all the enlargement of the cervical and *occipital glands had been completely absorbed*; only one of the submaxillary glands could be felt and even that was greatly reduced in size.

This case is a striking and obvious demonstration of the therapeutic action of kali bichromicum, even when administered, not indeed in infinitesimal doses, still, in doses totally ineffectual from an allopathic point of view (3x—5x potency = 1-1000 to 1-100,000 gr.).

By means of exactly the same experiments, I have repeatedly been convinced of the therapeutic action of the thirtieth potencies. Now, if the action of a medicine, administered according to the law of *similia similibus* in an infinitesimal dose, can be clearly proved *even once*, by means of a strictly logical and scientific experimental method, then, from a logical point of view, the whole question in dispute is settled once for all.

Naturally, this method can be most conveniently applied in chronic diseases in hospital and clinical practice. The only thing to be said to an honest and conscientious opponent: "Macht's nach, aber macht's genau nach!"

THE SIMILLIUM BY TOXICOLOGIC CONSIDERATION.—In the last May issue of the *London Lancet* there appear two articles relative to drug poisoning which are of some moment not only because of an insight into the drug pathogenesis of the two remedies cited—chloretone and colocynth—but of a realization of their indicated homœopathic use based on the data given.

The first named drug—chloretone—is considered by Dr. Donald E. Core, of Manchester. He states that it has been largely used for the treatment of chorea at the Manchester Royal Infirmary during the last few years and as resident medical officer at that place Dr. Core had had the opportunity of seeing three cases of definite poisoning by this drug. The first was the case of a female who had taken over 30 grains for toothache. There was extreme incoherence of thought and of speech,

contracted pupils, and diminished knee jerks. This condition changed to one of dulness amounting to semi-coma; the patient was roused with difficulty and did not respond in any way to questioning, and to external stimulation only when this was forcible. Despite gastric lavage and the use of a large enema the woman remained drowsy for some 24 hours, but ultimately was cured.

The other two cases cited by Dr. Core were under treatment for chorea and were taking routine doses of three grains of chloretone three times a day. The twitchings improved but in both cases a state of what is best described as imbecility supervened. They both showed contracted pupils, diminished knee jerks, and mental dulness; in the first a condition of stupor followed and was maintained for several days after the drug was stopped. A casual glance of these cases cited will clearly show that chloretone in the dynamized state would be of real valuation in those cases with semi-stupor who were incoherent in thought and speech. The other symptoms are also of value in arriving at the simillimum myosis, mental hebetude and diminished knee jerks.

The second article bore reference to colocynth and its toxicologic behaviour. This was the contribution of R. B. Roe, house physician, St. George's Hospital, as colocynth poisoning is comparatively rare the case may be of some general interest. A woman, 25 years of age, took 75 gr. of colocynth in powder on January 27th, at 10 A. M. At 11 A. M., after taking a cup of tea, she vomited, and for the next two and a half hours vomiting and diarrhea appear to have been severe. At 2 P. M. she came under the observation of her medical attendant, who found her free from pain, with a flaccid abdomen, which was not tender on palpation. The pulse was normal. She was given some thin arrowroot but was unable to keep it down. Vomiting and diarrhea persisted throughout the afternoon and early part of the evening. At 8.30 P. M. she felt better and was able to retain milk and arrowroot, after which she got some sleep until 5 A. M., when severe vomiting recurred, and at 9 A. M. she had brought up rather less than a pint of bilious fluid but the diarrhea had stopped.

Some hours later, her condition being the same, she was transferred to St. George's Hospital. On arrival she looked exhausted, her eyes were sunken, and the skin was dry; the tongue was dry and furred, and she complained of great thirst. The pulse was rapid, 120, full, strong, and bounding. The temperature was 100 degrees F. On further examination the eyes reacted to light and to accommodation; the pupils were equal. There were no pains in her limbs, but she complained of a considerable amount of abdominal pain of a colicky nature, and she was still retching a good deal. The abdomen moved well on respiration, was flaccid, but there was tenderness over the lower part of the abdomen, which was relieved by firm pressure. There was no incontinence, headache, or tinnitus aurium, and she was in full possession of her mental faculties. Morphine, gr.  $\frac{1}{4}$ , and atrophine, gr. 1-100, were injected subcutaneously immediately. Three watery motions, containing a considerable quantity of blood, were passed in the first two hours after admission, while five hours later she was still retching.

On the next morning (Jan. 29th) there were still some pain and ten-

derness over the abdomen, but she was able to retain milk. Her temperature fell to normal, but the pulse was still rapid, 120. The stools contained blood, but not so much as on the previous day. The urine, except for a deficiency of chlorides, was normal. The blood pressure was 115 mm. Hg., and an examination of the blood showed no abnormality. On the following day there was no abnormal pain or tenderness, the motions were becoming formed, and the test for occult blood proved negative, and from this point onwards an uneventful recovery was made.

Reference to literature shows how uncertain this drug is in its action, and also what a wide range of symptoms may occur. The smallest fatal dose for a human being appears to be a drachm, though Tidy stated that for a dog  $3\frac{1}{2}$  drachms is the smallest fatal dose. Orfila, however, relates the case of a man who took 3 ounces for gonorrhœa and recovered. In doses of from 30 to 60 gr. the most constant symptoms are shooting pains in the limbs, muscular weakness, drowsiness, a feeling of constriction in the throat, much thirst, abundant salivation, dysphagia, and sometimes a pruriginous eruption extending over the whole body. Larger doses of from 1 to 2 drachms give rise to additional and more severe symptoms—namely, trismus of the jaws and marked tonic contraction of limbs, the eyes become dull and sunken, the pupils dilated and fixed. The heart is accelerated at first, but a period of depression ensues, the heart-sounds becoming more rapid and fainter until they cease, while the respirations, which are also accelerated in the early stages, become increased, there being often marked dyspnœa in the final stages.

Nearly all the cases wherein doses of 110 gr. and over were taken have ended fatally, and in these cases the central nervous system is generally affected; giddiness, tinnitus aurium with increasing deafness, and, in one case, partial facial paralysis have been noted. The gastro-intestinal symptoms of severe vomiting, diarrhœa, and abdominal pain, which are constant features in all cases, become uncontrollable and lead to rapid collapse of the patient. The kidneys, when affected, are permanently damaged, and severe hæmaturia, with large amounts of albumin, accompanied by great frequency of micturition occurs.

With regard to the post-mortem changes, in some cases nothing abnormal has been found. Tidy, indeed, related one case in which the stomach was "preternaturally pale." In the majority of cases, both congested and pale areas with small ulcers of recent origin have been found on opening the stomach, while similar appearances with submucous effusions of blood in the small and large intestines have been noted. The liver and kidneys may be enlarged and congested, or may be normal. The great veins are generally distended with blood. The heart shows no abnormality; neither do the meninges or brain.

From this case it will be seen why this drug in homœopathic attenuation is so very valuable in shooting pains in the limbs as well as cases where abdominal cramp and griping are paramount. For the latter condition—that of a painful colicky state it was often used with great success by the late Professor Lippe.—*London Lancet*.

ICTERUS AND MALE FERN.—In a recent original communication in *Le Progrès Médical*, Achard and Saint-Girous, of Paris, speak about the



causation of icterus by hemolysis subsequent to the ingestion of ethereal extract of male fern in prevailing practice. Such a condition, according to these French observers are more prevalent in Germany and Italy where the custom is to give massive doses of this drug. The medicament is used for taenial disease.

Prior to Achard and Saint-Girous, two other French clinicians, Etienne and Perrin, also report two similar cases of icterus by hemolysis through the action of this drug. Therefore evidence is not wanting of the peculiar action of the male fern in the causation of certain blood disease. As the crude action of a drug is of vast importance in its indicated use in dynamized form, it would doubtless be true that this particular drug would be of great service in many of those blood dyscrasias showing the effect of some causal hemolytic poison. In parasitic disease it should prove of value—as it also should in jaundiced states and cholemia attendant of course on some retention in the blood of toxic material which the liver normally converts or eliminates.—*Le Progrès Médical (Trauxaux Originaux)*.

**DIPHTherium.**—We extract the following from Dr. Cartier's excellent work on "Therapeutics of the Respiratory Tract": The idea of curing diphtheria by diphtheria does not come from Bœhring nor Roux. Long before Pasteur a homœopathic German veterinary published a work on Isopathy, in 1833, showing that diseases were cured by their viruses. In 1874 Collet, a French homœopathic physician, treated diphtheria by dissolving some of the débris of the false diphtheritic membrane in two soup spoonfuls of water, shaking the same well, and from which he made the fifth alcoholic centesimal dilution. He moistened some sugar pills with this and gave them to his first case of diphtheria; the third day the membrane had completely disappeared. With the same preparation Collet treated an entire epidemic of diphtheria and obtained a complete cure in all cases which came to him the first three days of the disease. This is similar to the use of the anti-diphtheritic serum which is acknowledged useless after the third day. Dr. Cartier relates a case cured by diphtherium 200 after other drugs had failed. Dr. Cartier has had repeated success with diphtherinum in diphtheria, and believes its action to be quite as prompt as the serum. Our preparation should be made with the false membrane itself containing the bacteria and not with the diluted serum. There is never any post-diphtheritic paralysis following the use of this remedy as often occurs with the serum. The serum is truly homœopathic in genesis, but its application as usually employed is not.—*Medical Century*.

**DRUGS IN ECZEMATOUS CASES.**—In a recent article in the *Medical Century*, Dr. Glen I. Bidwell, of Rochester, N. Y., treats at some length of the remedies he has found useful in the treatment of eczema. He speaks about many of the most useful preparations in a very thorough way—among which, of course, sulphur, silicea, rhus toxicodendron and arsenicum album hold prominent sway. As Hahnemann long ago pointed out he justly emphasizes the use of a few preliminary doses of sulphur which always helps the eczematous case and paves the way for the exhibition of other remedies and a speedy cure. Sulphur like silicea

is a truly marvellous antipsoric. Sulphur is eminently useful as Dr. Bidwell shows in the *scabby* patient.

The eruptions of apis will be erythematous and show swelling and marked œdema. These will be worse on the face, lips, nose, ears, throat, hands and feet. There will be circumscribed spots that itch, burn and sting. There will be fine points at which there will be a stinging pain, this will be followed by intense itching. There may develop dark red papules with a deep red rash. The skin will often be swollen, and œdematous. Apis will often be indicated in maltreated cases where there develops meningeal symptoms. Your apis patient will be irritable, and hard to please. Your apis patient will tell you she has nothing to cry over but feels as if she must sit down and burst into tears. Rhus toxicodendron cures those cases which have a rather deep erythematous eruption. Here, of course there must be vesiculation. Rhus helps those cases where there is great *itching*. [In this respect—that of great itching it of course resembles *Dolichos Pruriens*.]

Antimonium tartaricum will manifest the pustular eczemas. The eruption on the hands and face will have a deep erythematous base and area, with itching pustules that soon dry up; pustular eruptions about the nose and face; vesicles all over the body which quickly fill with pus and dry into crusts; umbilicated pustules that are very similar to small-pox, globular pea-sized pustules which leave a scar or a bluish-red mark. The crusts formed by this remedy are thick and dark. The pustules formed by this remedy resemble very closely those produced by vaccination, and the resulting scar made by an application of the crude drug closely resembles the scar of vaccination. The tongue of the antimonium tartaricum patient will be white and pasty looking.

About the administration of the remedy, when indicated, will say that great care must be employed here or your results will be disappointing. [The higher the dynamized preparation the more lasting and curative the effect. The higher dynamizations have always proven quite rapid in action and active.—D. M.]—*Medical Century*.

REMEDIES IN COUGH.—In a recent issue of the *Pacific Coast Journal of Homœopathy* there was an excellent and short resume of a few excellently proven remedies for various cough indications:

*Ipecacuanha*. Cough constant, harsh, shaking and without result. It is inefficacious in the sense that the mucus, of which there is a great quantity in the bronchial tubes, cannot be expelled by coughing. The cough caused nausea, yawning and sometimes vomiting.

*Phosphorus*. A cough dry, rough and hoarse with pressure or oppression of the chest. [Oppression is not like dyspnea, as in pneumonia where of course lycopodium or sparteine sulphate is indicated.—D. M.] There is much burning in the larynx and behind the sternum.

*Spongia*. A dry, suffocating cough with pain and burning in the chest. The patient is very hoarse. There is a sensation of constriction in the larynx which makes breathing difficult. Difficulty in breathing often accompanies the dry, metallic cough and there is a sensation as if the breath passed through a porous substance. The dry cough and the constriction are both relieved by eating and drinking.

*Rumex.* A cough spasmodic, dry, incessant, worse from breathing cold air, from lying down, and in the night. The irritation causing the cough is due to mucus which causes a tickling behind the sternum. The principal time is from ten o'clock in the evening till midnight. There is relief from covering the head and breathing under the bedclothes.

*Sticta.* A nervous cough, dry, incessant, hacking, sometimes in spasms like whooping cough. Usually this is a remedy for nervous, reflex cough, and for whooping cough, but sometimes for the incessant, irritating cough of measles. Although nothing seems to ameliorate the cough of sticta, it is plainly worse towards evening, or when the patient is fatigued.

*Causticum.* Cough hollow, dry, hoarse, with pain and harshness descending into the trachea. The cough of causticum is the opposite of that of rumex in that it is worse from being warmly covered in bed. It is relieved by small swallows of cold water. The sensation as of mucus in the larynx which the patient cannot expel is very marked with causticum. With the cough there is involuntary emission of urine.

*Bryonia.* Cough dry, hacking, from irritation in the upper part of the trachea. Every time the patient coughs there is a sensation as though the head and chest would burst. The bryonia cough is sometimes called a stomach cough because it is worse from eating and drinking. With the cough there is an acute, stabbing pain behind the sternum, in fact, through the whole chest. After some hours the cough becomes a little moist and there is expectoration of a small quantity of mucus streaked with blood. There is marked aggravation of the cough in going from a cold to a warm place.—*Pacific Coast Journal of Homœopathy.*

**BRYONIA IN RHEUMATISM.**—W. S., aged 19, had rheumatism when 12 years old, which left him with mitral regurgitation. Present attack began April 22 with sharp pains in left ankle, then in right ankle and both knees, worse on touch or least motion; joints swollen, skin pale, patient anemic, very thirsty, tongue coated white; urine scanty and of dark color; temperature 102; pulse 80. Bryonia 3x was prescribed with local applications, which caused gradual reduction of temperature, with amelioration of all symptoms within six days.—*Dr. George H. Ding.—The New England Medical Gazette.*

**KALI BICHROMICUM.**—The conditions under which this most valuable drug is indicated is well brought out in a recent issue of the *Homœopathic World*.

This remedy has a specifically-selective action—

(1) On the skin, where it causes a cutaneous eruption, principally in the form of pustules and papulæ, which are often taken for syphilitic, and also ulcers, which leave a depressed cicatrix on healing;

(2) On the mucous membrane of the mouth, nose, respiratory and digestive organs, where it causes inflammation with a tendency to suppuration;

(3) It has also an undoubted tendency to cause a destructive ulceration of the nasal septum, and to bring on various osseous and rheumatoid pains in different parts of the human body.—*Homœopathic World.*



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## TUBERCULOSIS OF THE SKIN. MANIFESTATIONS, DIAGNOSTICS AND RESUME OF TREATMENT METHODS.

BY

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(Read before the Annual Meeting of the American Institute of Homoeopathy at Denver, Colorado, July, 1913.)

MUCH has been said and written upon tuberculosis of the skin during the past few years, which is of interest and worthy of note.

I shall consider both types of tubercular manifestations, whether definitely tuberculous in nature or whether para-tubercular in character. By the term "definitely tuberculous" I refer to those conditions in which the tubercle bacilli can be definitely demonstrated, either by the aid of the microscope or by the results of injections into the guinea pig. By the term "para-tubercular" I refer to such conditions which are the results of the presence of tuberculous toxins in the blood and in which no tubercle bacilli can be demonstrated.

Under the definitely tuberculous skin affections I shall consider first lupus vulgaris, which is the most frequent form and most typical, including the clinical form known as lupus verrucosus or tuberculosis verrucosa cutis. Secondly, I shall consider miliary tuberculosis; thirdly, erythema induratum of Bazin; and lastly, scrofuloderma.

Under the para-tubercular affections I shall consider folliculitis and acnitis, acne, scrofulosorum, and finally, lichen scrofulosorum.

I shall begin my general discussion with a few words on the

causal factors which are responsible for tuberculous dermatologic affections.

It is a well-known fact that tuberculosis may develop locally, being the result of direct inoculation. This being vouched for by Gilchrist, of Baltimore, who reports a case of primary tuberculosis of the sole of the foot; the diagnosis being confirmed by the finding of tubercle bacilli microscopically. He reports another case in which the patient had tuberculosis of the back of the right hand, being from a scratch mark. The patient having worked at the same bench with a consumptive, while the former patient lived in the home of a consumptive who expectorated upon the floor, the patient having the affection upon the sole of his foot, having frequently gone bare-footed. Babes in the *Presse Medicale*, gives the results of his experiments of rubbing pure cultures of tubercle bacilli into the skin of guinea pigs. In some cases the skin was shaved, while in others the hair was merely cut away. The bacilli penetrated into the shaved skin with readiness, and in some of the cases where the hair had merely been cut off.

Lasser found three per cent. of the employees of one of the slaughter houses of Berlin affected with tuberculosis of the skin. The most of these affected were employed in the inspection of tuberculous meat, especially those engaged in doing microscopic work. All of them were stout, robust men in the best of health, with no manifestations of tuberculosis elsewhere, the skin lesions being slight. Lasser explained this by the fact that predisposition did not exist.

The virulence of the germs is diminished after death, being usually active only in the living circulation. There are, furthermore, many cases on record which clearly demonstrate the direct inoculation of cutaneous tuberculosis.

There are, however, other ways in which tuberculodermata may arise: for instance, by extension from deeper tubercular foci, or by transmission through the veins or lymphatics; then again, through the blood, and lastly in utero. It must be remembered that about one-third of those affected give a tuberculous family history, while tuberculosis in other parts is occasionally seen. Individual resistance plays an important role in the progress of the disease. In those who are robust and without predisposition there is little tendency for progress and usually goes on slowly without suppurative lesions. In those of the strumous diathesis and who are apt to be cachectic, the

lesions develop more rapidly and are apt to be destructive and ulcerative.

I shall now take up the consideration of lupus vulgaris. That lupus is more or less rare in this country we all agree. It is common, however, in Great Britain and Europe. Usually about two-thirds of the cases are to be seen in women. The poorer classes and those surrounded with unhygienic surroundings are usually the most susceptible, although no class is exempt. Lupus usually begins in childhood, and has been seen beginning as late as the sixty-third year. About 75 per cent. of the children affected usually have the beginning lesions at the edge of the nose or upon other portions of the face. This is explainable because children frequently have the habit of picking their noses, and where there is tuberculosis present in the family one can readily see how such a tuberculoderm can be transmitted, for children are forever having their finger nails in mourning, carrying many thousands of germs beneath them.

Lupus begins as a small, flat papule, deeply imbedded in the skin. It varies in size from that of a pin point to that of a small pea. It is brownish-red or yellowish in color, and according to Hutchinson has that characteristic apple jelly appearance. Many of these initial papules often appear as the beginning lesions of lupus,—growing slowly, but surely and definitely. It is after a few of these papules have definitely established themselves that they take on the apple jelly-like appearance. They are softer than the surrounding skin in which they seem to be imbedded. In time these papules tend to enlarge, and either break down into ulcerating masses, or they undergo fatty degeneration and are absorbed without ulceration. If there is a tendency for ulceration they break down with the formation of ulcers, which are round or irregular, with flat, flabby borders and indolent red, granulating bases. Purulent secretion occurs usually drying into dirty yellowish-greenish crusts. White scarring is characteristic, and where the lesions are quite superficial the scars are very thin; while in the deeper lesions scarring is quite thick and dense.

The most frequent location of this disease is upon the face, especially upon the nose, cheeks and ears, although no part of the body is exempt, even attacking the mucous membranes of the nose and mouth. The disease is practically a painless one



without constitutional symptoms, and gives rise to various pictures in its coalescence and configuration.

Occasionally lupus may present itself as discrete tubercles on an inflammatory base which is dull red and which may show slight ulcerations. Again it may present itself as groups of discrete tubercles distributed upon different parts of the body; then this condition is known as discrete or disseminated lupus. Then again lupus may take on a hypertrophic form in which the nodules present themselves about the borders of the lesions as hard, firm, brownish lesions. The center of the lesion tends to remain soft, which may undergo involution, or there may be a tendency for the nodules to enlarge and produce a decided tumor-like appearance. Occasionally, secondary infection of lupus lesions takes place, with the formation of exuberant granulations, with the production of papillomatous lesions which may be dry or suppurating. Lupus as well presents itself in serpiginous outline and as well in annular outline. It must be remembered that scaling is a definite, characteristic feature of lupus tubercles, and that there is a variety that closely resembles lupus erythematosus which has an entirely different entity and which does not have the characteristic jell-like tubercles present.

Occasionally lupus will undergo fibroid thickening, the tubercles becoming hard and resistant, with decided enlargement of the part affected. Usually lupus is very slow in its progress, but occasionally, however, it may take an acute form, spreading with great rapidity and associated with rapid tissue destruction. So much then for a description of lupus.

Diagnosis from allied conditions would next naturally interest us. I shall give a few of the more important points of differentiation from epithelioma, tubercular syphiloderma and lupus erythematosus. Let us remember that in lupus vulgaris the course is slow, usually develops before puberty, there is little or no pain, ulcers are usually multiple and superficial, while the edges and base are soft; whereas in epithelioma the course is more rapid, usually develops in middle or later life, may become painful, the ulcers are single and deep, while the edges and bases are hard.

With reference to differentiation from tubercular syphiloderma we will remember that we might have a history of infection, the course is rapid, there might be the usual concomitant signs of syphilis, the nodules are hard, the ulcers are deep.

with clear cut edges, there is a copious discharge with the formation of thick, heavy, greenish crusts, the scars are usually soft and smooth, and there is rapid healing under mercury and the iodides.

In contrasting lupus erythematosus with lupus vulgaris we will bear in mind that lupus erythematosus develops in adult life, that the disease is quite superficial, that the lesions are well defined scaly patches, that ulceration never occurs, and that the disease is probably closely associated with seborrhoeic disorders.

The methods of treatment of lupus vulgaris as advocated to date are many and varied. Each month dermatologic literature brings us tidings of remarkable cures. Some of these I shall present to you; but first I shall mention the older methods, referring to the use of strong ointments and solutions with the hopes of destroying the lesions. Salicylic acid, a drachm to the ounce of ointment base, or the same strength dissolved in traumaticin. Resorcin may be used in the same way. A ten per cent. ointment of pyrogalllic acid is of benefit, used three times daily for a week. It may as well be incorporated in traumaticin with salicylic acid, ten per cent. of each.

Whenever any of these combinations have been used to the point of inflammatory reaction, a mild soothing ointment should be used until the reaction is controlled.

Cauterization, curettment, scarifications and excision may be used from the surgical standpoint. Radiography, high frequency currents and the X-rays are all of use. Refrigeration, electro-dehydration and thermo-albuminization have all been used with success by the author. Tuberculin, according to McCall Anderson, has given excellent results; others voice their sentiments quite to the contrary. Professor Landerer, who died some years ago, suggested the use of Hetol, derived from Peruvian balsam, in the treatment of lupus and other tubercular ulcers, contending that he had excellent results from its use. He died before his result could be definitely announced.

Dewar treated a case by injecting intravenously fifteen minims of an ethereal solution of iodoform, plus liquid paraffin every second day, and within forty days the patient was cured completely. Werther gives the potassium permanganate treatment as follows: Compresses soaked in a one per cent. solution are applied to the diseased part and changed frequently. To any ulcerated areas he applies the dry powder, and

deep seated nodules he sticks with a pointed match, first dipped in boiling water and then in the dry powder. Dreuw, in the *Berliner klin. Wochenschrift*, has devised the following treatment no matter how deep the lesion. He first freezes the part with ethyl chloride, a treatment he has long advocated. He then rubs in crude carbolic acid which has been saturated with free chlorine. One must necessarily fear deep scarring in such a procedure as this. Finally, Winkelried Williams, in the *British Journal of Dermatology*, advocates the therapeutic value of fluorescent substances and sunlight. A five-tenths per cent. watery solution of eosin is swabbed on the lesion until it is stained a decided pink. The patient then exposes the lesion to the sunlight an hour or two a day. Treatment is usually continued from one to three months. Williams reports a number of cases successfully treated.

Constitutional treatment is not to be neglected, and is to be followed out as indicated in other forms of tuberculosis.

The indicated homœopathic remedy I shall consider at the close of my discussion.

I shall next call your attention for a few minutes to that form of tuberculosis which is usually seen upon the hands of anatomists, pathologists, butchers, etc. This form is usually known as tuberculosis verrucosa cutis, and is essentially the same as lupus only that there is greater papillary hypertrophy and that the tubercle bacilli are more easily demonstrated. The lesion consists of a warty papillary surface with pus exudation from between the papillæ, with more or less crusting. The base is firm, inflammatory with an absence of the jelly-like tubercles. There may be a tendency for central healing with scar formation; the process is a very slow one and at times may undergo spontaneous involution. The lesions are usually single, although they may be multiple. The treatment is essentially the same as for lupus.

Miliary tuberculosis of the skin is a rare affection occurring with and independently of internal tuberculosis. In the form of true miliary tubercles they are rarely seen for they soon break down into soft, flabby, round or irregular ulcers, exuding a seropurulent secretion which forms into thin yellowish crusts. They usually appear at the orifice of the body, although they have been seen elsewhere.

Erythema induratum, or Bazin's disease, presents itself usually upon the backs or sides of the calves as painless, indo-



lent nodules which usually break down with the formation of ulcers. When they first appear they are bright red, but later become purplish, surrounded with areola which is either dark red or purplish. They may undergo involution or break down with the formation of deep, irregular ulcers not unlike ulcerating syphilitic gumma.

Scar formation is characteristic both in the ulcerative and non-ulcerative forms. The ulcerative forms leave deep, pigmented scars which are surrounded with a persistent halo usually dark red or purplish. The non-ulcerative form results in slightly pigmented atrophic scars.

The disease is a decidedly chronic one, slow in its course, and is amenable to refrigeration or to surgical treatment, care being taken to support the limbs with bandages, and keeping them in an elevated position as much as possible. The indicated remedy here does good and is not to be neglected.

Scrofuloderma is not a true tuberculoderm. It is usually seen at the side of the neck in conjunction with cervical tubercular adenitis. Occasionally they are seen in the axilla, and may be seen wherever there is a tubercular gland infection. The lesion usually presents itself as a bluish patch pierced with several sinuses connected with the underlying suppurating tubercular glands. Suppuration from the skin may occur due to pyogenic infection, or tubercular foci may be occasionally found, which, however, is the result of secondary tubercular infection. Refrigeration treatment is usually advised in these conditions, but it is to be borne in mind that the properly indicated homœopathic remedy has more than once brought about the proper results.

Finally I shall have a few words to say about the paratubercular affections. Acnitis and folliculitis (both of which have many synonyms) are probably one and the same thing, probably differing only in the distribution of the lesions. They both present themselves as indolent dark red papules which are inflammatory, become purulent and run a chronic course. They are seen in those with a tuberculous family history and who are cachectic.

In the first named condition—acnitis—the papules usually group themselves around comedones, upon the chin, the cheeks, over the eye-brows and temples; while in the condition known as folliculitis the papules are more likely to be seen upon the

hands, feet, forearms and legs, although the face may be attacked. There is a marked tendency for scarring.

Acne scrofulosorum is usually seen in tuberculous children, presenting itself upon the lower part of the body and upon the lower extremities as groups of minute papulo-pustules. They are about the size of a pin head, about the hair follicles, and upon a red or purplish base. The eruption is as a rule profuse, is quite chronic and is occasionally seen in adolescents.

Lichen scrofulosorum, like the preceding condition, is seen in children and adolescents of the tuberculous type. The papules in this condition tend to group themselves circinately or in the form of a crescent. They are seen about the hair follicles, are surmounted with a fine scale, rarely with a pustule, and are decidedly chronic with a tendency to spontaneous disappearance, only to re-appear. The lesions are usually to be seen upon the lower half of the body and are dark red in color. There are no subjective symptoms. The indicated homœopathic remedy should always be given the utmost attention. Not that it can possibly be expected to cure an advanced lupus, but that it can and has affected its earlier stages, and that it has cured other of the tuberculodermata is not to be denied.

Tuberculinum (Raue) about the 6x seems to give good results in the slow and persistent types of lupus. Arsenic, arsenic-iodide, aurum mur., baryta carb., baryta iod., calcarea phos., calcarea sulph., fluoric acid, graphites, hydrocotyle, kali bichrom., kali brom., kali mur., kreosote, lycopodium, mezereum, natrum mur., phosphorus, phytolacca, psorinum, silicea, staphysagria and stillingia all have their definite indications and are productive of good.

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CHIMAPHILA UMBELLATA IN CATARRH OF THE BLADDER.—Chimaphila is indicated when the following symptoms are present: Offensive urine, turbid, containing bloody or ropy mucus, with a copious sediment; burning and scalding during urination, followed by *straining*; difficulty in beginning to urinate, with a deal of *straining*; urine often foetid; scanty urine. acute prostatitis, accompanied with retention of urine, and a feeling as of a ball in the perinæum whilst sitting; great urging to urinate, constantly waking; urine often increased, and of a greenish hue; a *fluttering* sensation in the region of the kidneys, shifting from one kidney to the other. painless, and without uneasiness; a feeling as if the blood was on fire. with dry skin, hot flashes, burning of the feet and sexual excitement. [The above indications as a guide to simillimum are really excellent. The contribution is that of Frederick Kopp, of Greenwich, New South Wales.]—*Homœopathic World*.

## Transactions of the New Jersey State Homoeopathic Medical Society.

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### TREATMENT OF NEPHRITIS.

BY

CARL A. WILLIAMS, M. D., PASSAIC, N. J.

THE subject of my paper is really the "Treatment of Nephritis" rather than the "Diet in Nephritis," as I was asked by the chairman to go into the treatment somewhat, outside of the dietetics of the disease.

During the last fifteen years more has been accomplished to place practical dietetics upon a scientific basis than ever before. The study scientifically of food-stuffs upon the human economy, and how to best feed persons suffering from disturbances of metabolism has had an indefatigable worker in this field, and who has probably done more than any other physician along these lines. I refer to Prof. Carl Van Noorden, of Vienna. Many of his views at first were so revolutionary and out of the ordinary that it was some time before the medical profession at large accepted his clinical studies. However, I think I am safe in saying that the present day methods of feeding diabetics and nephritics are largely based upon his ideas and experience. As you all know he has been fortunately placed in a position where he could study and follow a large number of these cases.

The whole object, as I understand it, in dieting nephritics is to spare the kidneys all the work possible, and at the same time to keep up proper nutrition.

This is the problem we have before us, and it certainly taxes our best endeavor in many instances. First I will speak of the treatment of acute nephritis, then secondly, cases of persistent albuminuria without any other symptoms of nephritis, and thirdly, chronic nephritis, which includes both varieties, the large white kidney of Bartels, and the contracted granular kidney.

In acute nephritis absolute rest in bed is necessary. But the position of the patient should be changed often to prevent



hyperstatic congestion of the kidneys, which often occurs if the patient remains on his back any length of time. The patient should remain in bed until the albumen and other kidney elements have disappeared from the urine. If we have made sure that the urine is normal the patient can be allowed up for a short time each day, but not within an hour or two after a meal. If after exertion the albumen should reappear in the urine, he should be ordered back to bed, and to remain there until the albumen disappears again. Unless this precaution is taken there is great danger of chronic nephritis developing.

Dr. Van Noorden claims there are four possibilities regarding the outcome of the acute cases. First, they run a course of a few days to a few weeks, clear up and get well. Second, cases in which the albumen finally goes, but after a few months or a year or two it returns again. Cases behaving in this manner usually turn out poorly, and he considers this a very unfavorable sign. Third, in other cases the albuminuria remains, and is persistent, and strange to say, this is not a bad sign provided there are no other symptoms of nephritis present, such as hypertrophy of the left ventricle, high blood pressure, etc. The fourth possibility is the development of chronic nephritis.

The diet in acute nephritis during the stage of active inflammation should be scanty and non-irritating. The principle of sparing the kidneys by relieving them of the task of excreting much solid excrementitious matter is the important indication and should be carefully observed.

A milk diet has been the standard for acute nephritis for many years. But a number of careful observers claim that even milk burdens the kidney in the acute form. This view is contrary to what we are accustomed to believe, but it is well worth our consideration. The diet now in use consists less of milk, more of carbohydrate food, as oatmeal, oatmeal jelly, barley and its various preparations, wheat, puree of potato, cocoa, fruit juices, a little bread or zwieback, and boiled vegetables. Carbo-hydrate food is claimed to make no demand on the kidneys. Also butter and fat do not make any demand on the kidneys. The objection that is being made to milk is that it is mainly composed of proteid material, salts and water.

I have been an advocate of a milk diet in acute cases, the milk acting as a gentle diuretic, and suitable food, but I confess that the reasoning of these recent observers appears to me pretty sound. In the acute cases with oedema, the ingestion of

salt should be restricted, as it is a well established fact that sodium chloride cannot be easily eliminated through the kidney when inflamed, and it is an important factor in causing the œdema of nephritis.

Our ideas in regard to the use of abundant water drinking are also erroneous, according to recent investigation. The administration of abundant quantities of water in acute infectious diseases is considered a useful measure to dilute the toxins, and stimulate elimination. This does very well while the renal structures are not impaired, but during the period of acute inflammation I think it is obvious that large quantities of water only increase the pressure within the arteries, and cause more work for the heart, which is already overburdened, on account of the peripheral resistance in the kidneys.

One should be guided in the matter, in the use of water, largely by the function of the kidneys. If they cease to excrete abundantly it is unwise to try to force them to eliminate water. The water that is used to allay thirst, etc., should be plain spring water rather than the large number of advertised mineral waters on the market.

Well nourished persons who come down with nephritis can get along very well for several days with practically no food. The fact that patients are forced to consume their own tissues, and are poorly nourished by this procedure, need not deter us from carrying out this plan, inasmuch as under-nutrition lasting for a few days can do no harm. This plan has worked particularly well in cases of acute nephritis in children.

Next the cases of persistent albuminuria. These people usually live many years, and may reach old age. Life insurance companies are still very particular in taking risks with such patients, but no doubt the time will come when this class of cases will be able to get life insurance. These persons need not follow any prescribed diet, but should lead a careful, temperate life, avoiding as far as possible all noxia, and may work and marry.

#### CHRONIC NEPHRITIS.

The newer conception of chronic Bright's disease is that it is a general toxæmia in which the kidneys, heart and arteries are principally involved. There are several theories in regard to its etiology, the main one of which I think is that a deranged bowel function leads to the abnormal disassimilation of albu-

mens, chiefly due to the action of putrefactive bacteria. Alcohol, lead and syphilis are prominent etiological factors, but meat plays an important role.

Our notions in regard to urinary findings in nephritis have recently undergone some modifications. It is a well known fact that some cases can be near their end with a fair urine. Casts are not regarded of such grave importance as formerly. Osler says when casts appear in the urine at fifty years, it simply means "less meat and less work."

The 24 hour amount, especially if nocturia be present, and the low specific gravity, is considered of more importance than the presence of casts or a large or small amount of albumen. These are the modern views in the matter of urinary findings. Does your experience confirm these observations?

#### NOW THE DIET OF CHRONIC NEPHRITIS.

The general nutrition of these patients must be maintained by the proper amount of food. They should receive the proper number of calories, which is about 2000 per day, for the average person, and the aim should be, in selecting a diet, to have a minimum amount of proteids, and other materials that in their passage through the kidneys cannot irritate the renal epithelia. Usually 80 to 100 grams of proteid per day, between 3 and 4 ozs., one-third of which may be of meat, two-thirds some other form of proteid, such as fish, vegetable proteids and milk and eggs are prescribed.

There are certain forms of proteid food that are highly poisonous in nephritis, and these are those forms which contain extractives and toxic principles. All raw, rare, smoked, cured, or corned meats, soups, bouillons, and meat extracts as well as most gravies contain the extractives, and should be avoided. Internal organs like liver, spleen, kidney, brain, sweet-breads contain nuclein, and as nuclein is split up into purin bodies during digestion, these purin bodies are distinctly poisonous, and both irritate the kidneys and the cardio-vascular apparatus, and should be excluded from the diet of a nephritic. Old game and caviar are especially poisonous, the first very often containing ptomaines, and the last purin substances.

It is hardly necessary for me to state that alcohol, tea, coffee and tobacco should be avoided as far as possible.

There is an old tradition that red meats and dark meats are



more harmful than the light varieties, and while it is not believed that there is any particular difference in the form of meat, light or dark, personally I prefer veal, breast of chicken and lamb, and it is my custom to have beef omitted entirely from the diet of these patients.

A good rule is to never allow meat but once a day. Generally speaking, the nearer to a vegetable diet the nephritic can conform the better are his prospects. Fats are particularly rich in caloric value, and can be used quite freely. But we are between scylla and charybdis here, as the worse thing that can happen to our chronic nephritic patient is obesity. Spices should be omitted from the diet, and salt should be restricted to some extent in cases with œdema. One is only justified in restricting the salt intake when there is œdema present. The danger of giving too much salt is that it increases the water intake, and the water intake should be cut down so as to reduce the arterial tension, and lessen the work for the heart. Our best observers teach that water restriction is one of the best ways of reducing high blood-pressure, even more effectual than the high frequency current or nitrites, and less objectionable, as it is a great question to-day if the arterial tension is not simply a compensatory process. We are still in the dark as far as the etiology of high blood pressure is concerned. All mineral and carbonated waters are to be avoided. Plain spring water is to be used. One to one and a half quarts of water may be allowed during the twenty-four hours. Dr. Van Noorden has instituted what he calls drinking days. One day a week is selected during which abundant quantities of water are ingested. In this way the renal tubules are flushed, and accumulated waste products are washed from the blood through the kidneys and out of the body. Water drinking restricted in this way can do no possible serious damage, whereas ingesting large quantities of water every day weakens the heart and blood vessels, and proves a questionable procedure.

The fate of your case, leaving out uræmia, depends on the heart, and this is particularly the case in the vascular type of nephritis. Each person must be studied, and individualized, and above all your dietary restrictions must not be such that your patient loses weight and strength. His food should always be palatable, and quite recently Pauloff, in his little book on "Psychic Digestion," has called our attention to the important part that psychological processes play in this function. I

need not mention that rest and diversion, in cases that are able to do so, are valuable adjuncts in the treatment.

Vacations for those who are unable to rest completely do much to inhibit the course of the disease. Climates, a dry, warm, equable climate, like Southern California, or Southern France, are considered ideal. The œdema that is so persistent in some cases will disappear in a dry climate after failure in a moist one. Altitudes of 1000 feet and over should be avoided, especially in the more chronic cases. Gymnastics are sometimes used for stimulating the peripheral circulation.

#### BATHS.

Lukewarm baths are better than cold baths, and these can be conveniently used at home. The carbon dioxide baths cannot be carried on very well at home, and should be given under the supervision of a physician.

These carbon dioxide baths are especially well carried out in Germany at various health resorts. Artificial baths are prepared as they are wanted in this country, and there are several good places where these baths are given.

As I have mentioned, it is well recognized that the fate of the chronic nephritis cases depends upon the preservation of the cardiac muscle, and the object of these baths is to strengthen the heart, and lower arterial tension.

Dr. R. C. Cabot maintains that the treatment of chronic nephritis consists principally in treating the heart, as far as drug therapeutics is concerned.

Now a few words as to the drug therapeutics.

First.—What *not* to do.

Never give any physiological acting drugs in well compensated cases, and those of you present who practice pure homœopathy need not be so cautioned. But for some reason some of us do not always keep in the straight and narrow path, and have been guilty at times of using drugs for their physiological or anti-pathic action, and to those of us who do so, this caution is needed.

Another well-established therapeutic procedure has been questioned of late, and that is the use of iodides in arteriosclerosis. As we all know, those of us who are at all familiar with old school literature, the iodides have been recommended for arteriosclerosis from time immemorial.

Several leading physicians now claim that the iodides of sodium, potassium, etc., should not be used in chronic nephritis, as they are very irritating and harsh on the secreting structure of the kidney. Therefore, as chronic nephritis is seldom present without arteriosclerosis, and many cases of arteriosclerosis are associated with Bright's, the iodides do harm, and it is bad practice to use them.

Another old school caution, which I hope we as homœopaths will not try to imitate is the use of active purgatives. It is claimed that they very often cause collapse, and should not be used. Whether we as homœopaths should depend upon the dynamic action of our homœopathic remedy or resort to the cardiac stimulants, such as digitalis, strophanthus, camphor, and caffein preparations in the heart weakness that sometimes occurs is a more debatable question. And I hope you will freely discuss this point in my paper. Cardiac stimulants and diuretics, such as caffein preparations, as diuretin, etc., are used quite extensively by old school physicians and some homœopaths, but according to recent views they may irritate the kidneys, and this should always be borne in mind when using them.

Outside of the mode of living, *diet particularly*, my confidence is in the remedy that corresponds most closely to the totality of the symptoms, and that remedy to be given singly, and properly attenuated, and not at too frequent intervals, giving Nature a chance to re-act. While I realize that almost any drug in the materia medica from aconitum to zizia may be indicated if the symptoms call for it, I will just mention a few remedies, which in my experience, have been most frequently needed: Aconitum napellus, acetic acid (acidum aceticum), apis mellifica, apocynum can, arsenicum album, belladonna, cantharis, cuprum arsenicosum, digitalis purpurea, mercurius corrosivus and terebinthina. I will not go into the individual characteristic of each one of these remedies, as they are well known to you all.

Before closing I want to speak a few words about the most serious and common termination of nephritis, especially the vascular type, and I refer to uræmia.

There have been many theories and hypotheses regarding this train of symptoms, but no one seems to know exactly just what the pathology is of this condition. Bartels, Traube, Rees, Frerichs, Oppler, and others have made an exhaustive study of



this phenomenon, but have arrived at no satisfactory solution of the problem.

I think, however, the general feeling is that uræmia is due to the retention in the blood of certain excrementitious elements or materials that should be eliminated. Some think it is an intoxication or rather an auto-intoxication similar in character to the acidosis or acetonæmia of diabetes mellitus.

Dr. Richard Hughes in his "Principles and Practice of Homœopathy," on page 625, after mentioning the different remedies that members of our school have used, of course upon homœopathic indications says, "Nevertheless the evidence in favor of the ultimate dependence of such symptoms upon blood contamination of some sort is so strong that I should advise you not to content yourself with internal medication, but to promote diaphoresis to the utmost extent in your power, as by a hypodermic injection of about grain 1-6 of pilocarpin." I am afraid to use pilocarpin unless I have a good strong heart muscle, and as hot vapor baths will start the skin to action quite as well as the pilocarpin, and without as much danger to the heart, I much prefer their use. The remedies that have served me well, when uræmic symptoms have manifested themselves are: *Apis mellifica*, *cantharis*, *cuprum arsenicosum*, *opium*, *picric acid*, *terebinthina*, and *verat viride*, according to the symptoms.

Dr. W. W. Blackman, of Brooklyn, informs me that he has had excellent results from picric acid in seemingly hopeless cases of uræmia, with complete anuria. And from the kidney symptoms calling for its use, in Allen's Handbook, I am surprised it has not been used more extensively, as many cases we observe correspond well to its symptomatology found there.

Many claim that venesection is a life saver in uræmia. Also some prominent surgeons claim that decapsulation of the kidneys prolongs life in suitable cases where it has been employed.

Instead of going into the various foods and their caloric value, I have had printed some food tables, which I will pass around, and which you may have if they will be of any service to you.

This list was prepared some time ago by Dr. R. C. Cabot, of Boston, and shows the food value of each article. I have found this list very useful, especially in giving dietetic directions to diabetics.

I thank you very much for your attention.

References:—

Van Noorden's "Diseases of Metabolism."

Van Noorden's Lectures.

Dr. R. C. Cabot's Notes.

Croftan's "Clinical Therapeutics."

Hughes' "Principles and Practice of Homœopathy."

Allen's Handbook of Materia Medica.

Custis' "Practice of Medicine."

H. C. Allen's "Materia Medica."

Delafield's Notes.

Farrington's Clinical Materia Medica.

DISCUSSION ON DR. WILLIAMS' PAPER.

The discussion on Dr. Williams' paper was opened by Dr. H. C. Reynolds, of Passaic.

DR. REYNOLDS.—I have enjoyed this paper very much. I have had the paper, but have been so busy I have not had opportunity to read it. I have followed Dr. Van Noorden very closely on dietetics. I am particularly interested in what Dr. Williams says about diet, and agree with him in his remarks upon milk.

I think his suggestion in regard to carbohydrate diet is a good one. There is one thing that comes to my mind—the decapsulation of the kidneys. I have done the operation several times, and have followed cases where other men have operated, and the results have been very gratifying. It relieved the patient very materially. I have seen Dr. Lloyd operate a number of times. In talking to me afterwards he said the results have been uniformly good. I think that is a strong recommendation, for he is a careful surgeon. I will leave further discussion of the paper to you.

DR. WESTNEY.—This paper delights me very much. I think we, as homœopaths, because of the great scope we have in the treatment of diseases by our homœopathic method, have forgotten the best part of the Hahnemannian teaching, which I think is, "Remove the cause." This paper brings to me the fact that in this class of cases the cause of the disease may be easily removed. I am interested in his method of giving no food for two days. I believe in not giving food for three days. I did not want to say anything while Dr. McGeorge was here, about giving so much water in pneumonia. I believe it applies also to pneumonia—giving too much water in pneumonia or

kidney trouble. If I remember rightly, the blood pressure depends on the energy of the heart, the resistance of the arteries and the volume of the blood. One of the most serious complications in pneumonia and kidney trouble is the left ventricle of the heart dilating. You increase the volume of your blood by giving lots of water, you increase of necessity your blood pressure, and your weakened left ventricle has more work to do. Tagedadt gives some experience in that line. He injected into animals a saline solution, by so doing increasing the blood pressure. After that increase, nature tried to reduce it by increasing the secretion of the glands, and by increasing the excretion of the kidneys, and after that excessive excretion and secretion the animal was killed, and the liver found hardened and the kidney contracted. In these diseases, and Bright's, especially, in chronic interstitial nephritis with a small contracted kidney, by increasing water too much, you increase the blood pressure, you contract the kidneys still further, and you oftentimes cause uræmic convulsions.

And that calls to my mind that I was called to see a case of chronic interstitial nephritis with Dr. Allen, an old fellow, but he had little children. He said he wanted to live to see his children grow up. He was having uræmic convulsions every day, and sometimes two a day. He was on a diet much too rich in proteids, eating everything he wanted. I told him if he would live as we told him to he would live probably eight or ten years. So we took him off everything but skim milk and a very little water.

Strange to relate, as long as he was on that diet he did not have a convulsion, but as soon as he increased the proteid diet, increased the putrefaction in his intestines, with irritating effect upon his kidneys, he would have another convulsion.

DR. FOSTER, OF MONTCLAIR.—I want to say a word about these chronic cases we see so often in our business men patients, men under heavy business pressure. They break down at the point of least resistance, which in so many cases seems to be the kidneys. They are overloaded by wrong living, by too little out-of-door life and recreation, too much alcohol, too many cocktails before the meals and at other times, too much hurry, too much mental pressure centered on their business.

I have a number of such patients and I insist upon their taking a good vacation away from their business, yes, make them do it! You can get men of that age to play golf, for instance, and it will relieve the condition greatly.

DR. PERKINS.—I am glad to hear Dr. Westney bring up that point in regard to water. Water is a good thing, but you can give too much water and you can give too little water.



The point is to strike a happy medium. I think the tendency is sometimes to tell our patients to take plenty of water and whether you mean two or three quarts or two or three glasses of water, they have no way of telling; and I think it is very necessary to tell them how much water, be specific about it. Don't say "plenty of water." The point in regard to increased blood pressure, and increasing the work on the kidneys and the heart and the general condition of arterio-sclerosis, I think Dr. Westney brought out beautifully. I think in treating this class of cases we may give a certain amount of water and we must be very careful with regard to diet, especially in regard to restricting the proteid diet. In fact, sometimes when you give considerable proteid and you give no water at all you can increase the output of urine.

DR. C. H. CHURCH.—I was going to take the other side of the water question. I am a kind of a crank on water, but it does not simply want to be water. You want to take the other side of the question too. You want to get rid of that water. I suppose it doesn't make much difference whether you get rid of it through the skin or through the bowels or through the kidneys. Of course, in any case, you want to let up on the kidneys as much as possible, and you want to get out all you can through the skin and the bowels. I look upon these things, a great many of them, as autointoxication; as I sometimes tell my patients, they are dirty all the way through, simply loaded up with all sorts of refuse that should be taken out. You cannot keep the outside of your body clean with two or three cups of water a day, no more can you keep the inside of your body clean with two or three cups of tea or coffee a day. I say, "Push the water, but not too much at once, and then get rid of the water, chiefly by means of the sweat glands." Don't make them perspire, but sweat. Make them sweat all you can. Meantime you have got to push the bowels. But I think, as you say, you must get this poisonous matter out in some way. It is somewhat the same as Dr. Tagestadt's experiments with the injection of salt, you get too much salt. He also spoke of skimmed milk. I am perfectly satisfied to have them take that, instead of so much water. That is so much liquid to wash them out, but not too much at a time; and then, get it out.

DR. REYNOLDS.—I think Dr. Church is quite right about getting rid of the water. We know that nephritics sweat very poorly. There is only one other way to get it out, and that is through the kidneys; and the kidneys, in acute nephritis, secrete water very poorly. It does seem to me to be a very rational treatment.

DR. CHURCH.—One case I knew of,—in the first place the

man was having I don't know how many watery movements. We were trying to stop it. He was having an awful diarrhœa, as we thought. Then I said, "Here, if he will get that out of him, I don't care how much it goes." I think he had seventeen or eighteen watery movements a day. When I first saw him he was in bed. We did not think he would get out of bed for a long time. But within one week he was sitting in a chair, and in two weeks he was back in New York at business. I do not doubt that he was cured, by thus washing it out of him, in that case through the bowels. I do not say, "Through the kidneys." I say, "Through the bowels and the skin."

DR. PERKINS.—It stands to reason, if the kidneys are not acting properly and you keep shoving in water, it will excessively stimulate the kidneys and they will not work. If you don't get rid of that water you are in danger of coming to a condition of dropsy. I think Dr. Church's idea was simply calling upon the bowels to do the work of the kidneys.

DR. CORSON.—I am glad to have heard this paper. I am glad to hear about the carbo-hydrate diet in preference to the milk diet. In this question of fluid, he gives his man a flushing of water once a week. He does not allow the water daily, thereby increasing the blood pressure, but he indulges him once a week. It works very well, on the same principle,—if you take a patient who is restricted as to sugar and once in a while let him have a little sugar, something sweet, it seems to do him good.

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### REMEDIES IN STUBBORN CASES OF PNEUMONIA.

BY

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HOMOEOPATHY, as a healing art, has always been pre-eminently successful in the treatment of pneumonia. But with acute, regular, uncomplicated cases of this disorder, I may state at the beginning, my paper has nothing to do. Rather it is my intention to dwell on the symptomatic "snarls," which so often intrude themselves, when the patient's full recovery should be in sight, at least.

Let us therefore, first consider those cases of unresolved pneumonia, where the patient, in his failure to react from the acute stage, has been the victim of poor prescribing, overdosing, or too frequent repetition of the dose. Discrimination,

good judgment, courage, and powers of keen observation, are here in especial demand, for we have arrived at the trying "waiting period" of affairs. The exercise of these virtues may enable us to rightly deduce some reason for our patient's jumping the track on his road to recovery. We reassemble our symptoms, and are not afraid to wait for the appearance of some guiding light, which will lead us to the employment of a second remedy. This is the juncture where measures of meddlesome, deplorable, heroic physiological assistance often mar and obscure the vital facts in the case, for which we should so painstakingly seek. Occasionally, this investigation leads us far afield, and tucks the pneumonia comfortably out of sight, while we dip back into some hidden dyscrasia of our patient, and resurrect an old buried affliction perhaps, not appearing in the anamnesis of the present case, but which nevertheless, has been secretly revived, to fasten its fangs anew on its victim, in thus complicating and retarding a normal convalescence.

Such an obscure opening up of old sores, many times accounts for the mysterious half-recoveries from acute maladies, which we almost daily encounter. Hahnemann, of course, covers this whole field in his chronic diseases. Even his superficial students glibly proclaim some small knowledge of these facts, when they suggest the administration of sulphur, or psorium for conditions of poor re-action, but these great antipsorics must here, as elsewhere, fit the patient, and not the theory, or they will fail you first, last, and always.

Only recently, I have had this point brought very forcibly home to me. A patient of mine, an old man, has had pneumonia. Arsenicum iodatum was apparently indicated in the beginning, and carried him along swimmingly for a few days, then "breakers" appeared, in the guise of many fluctuating and misleading symptoms, so to speak. A game of "hide-and-go-seek" literally began, till after prescribing sulphur, which failed me utterly, I decided that the enemy, though aroused, was not yet ready for a good fair fight in the open; so I watched and waited. The pneumonia finally disappeared, but my patient was not recovering. Involuntary stools, thirstlessness, dry mouth, etc., finally spelled *apis mel*. *Apis mel*. gallantly went to the rescue, and we have had no further trouble.

I am quite willing to admit that the method of non-interference, in many cases, is a difficult one to sustain. We feel that our measures for the relief of our patient must at least



approximate the activity of the disease energy, or the race will be against us. But once we appreciate the often irreparable harm that premature, inadequate, and unhomœopathic medication may entail, we learn to detach our anxiety, and await clearer indications. Occasionally, we find ourselves in the embarrassing predicament of the snake that swallowed the two frogs. Having breakfasted on one frog, his snakeship stuck his head through a hole in the fence, and greedily dispatched frog number two. Upon seeking to wiggle back, Mr. Snake found himself pinned between the ingested frogs. Like the patient on his way to health, a certain amount of "obstacle absorption," or removal, is necessary before he can move. Frog number two may be likened to the post-state of debilitated inaction in acute disease; frog number one, the old unfinished score of a by-gone physical disturbance. A happy snake needs to have both removed. This is precisely what the fathers of our school have always urged upon us to do. If modern scientific medicine has ever evolved a better, safer, more uniformly successful working principle, than the one laid down by Samuel Hahnemann, so many years ago, I have never felt moved to adopt it.

In bringing to your notice the following remedies, I shall attempt briefly, to flash a general outline of the medicines before you, and then indicate their concrete application to the peculiar type of pulmonary affections, under discussion.

To successfully medicate these cases of arrested improvement, requires considerable skill, whether the initial bungling has been our own, or another's. If, however, we are able to grasp this new relationship to our patient, where evils of faulty prescribing must often be overcome, and at the same time, adequately recognize the progress and needs of the diseased state, per se, the employment of these remedies will certainly bring about favorable results.

A string of "characteristic" symptoms, outside of our text or reference books, possesses no power of holding our attention. It is only when the pictured relation of drug and disease, is clearly and strikingly portrayed, when definite points of similarity and difference, can be suggested in such a way that our memories are pricked, stimulated, and made to retain the facts for future use; that anything worth while is accomplished.

I will first introduce ferrum iodide, and ask you for a moment, to consider one or two unique features of this remedy.

What single symptom in pneumonia might suggest ferrum iodide to you, assuming, of course, that you have cleared the field of prejudice, in the form of any listed remedies for pneumonia, and have gotten down to real personalities with the patient. Cough and weakness, pain and restlessness, fever and sweat, are brushed aside as "generals," disregarded for the time, as being characteristic of pneumonia, but offering no special help, in this particular case.

No matter how extensive and profound our acquaintance with our materia medica may be; no matter how thoroughly we may decry the practice of prescribing on "key notes;" a "keynote" or one peculiar individual symptom, nevertheless, arouses a series of associated ideas, or memories in our mental make up, and a remedy arises before us. The successful prescriber is he who can the most readily and unerringly "spot" this symptom or peculiarity, and then proceed to a clearer discovery of a number of correlated supporting factors.

To dispose of our "generals" then, under ferrum iodide, we will pass over the weakness, and soreness in the chest, the short hacking cough, the night and morning aggravation, and look for the particular, which will give us the main thread in the tangle. Questioning in these cases is a necessity, for interrogation as well as observation, leads us to the goal. In this instance, an inquiry will bring out the fact, that the patient's urine is remarkably sweet smelling. A trivial point in pathology, perhaps, but a pivotal one to the materia medica man. It instantly calls up ferrum iodide. He now, recognizing that the patient belongs to the mecurial or scrofulous diathesis, proceeds to unearth a history of enlarged glands, and finally, bit by bit, he lines in a composite picture of both ferrum and iodine.

Again we approach the bedside of the hyper-sensitive patient. He is sensitive to cold, to his surroundings, to people. He is fearful of being touched, even looking askance at the stethoscope, so fearful is he of being hurt. He argues, and is disagreeable to his nurse. He is frightfully intolerant of his illness. This mental irritability, associated with the extreme sensitiveness, very quickly suggests hepar sulph. Further investigation reveals the tendency of every little cut, or scratch to suppurate. You will hear of the offensiveness of all the exhalations of the body. You will learn that he has always been sensitive to the cold. He will not undress where a vestige

of moving air may reach him. Of course, he avoids lying on the affected side. He will hold himself rigid in bed, lest by some mal-adjustment of position, his body impinges on the painful area. Hepar, as you can readily see, finds its place late in an attack of pneumonia. In those cases, where mild suppuration ensues, or in cases of croupous pneumonia, its application may be called for. We all know the character of the hepar cough, for most of us have heard it, in our nurseries, just before the cocks crow in the early morning.

Our next visit is to an excited anxious patient. His impulses are varied. His melancholia is tinged with contradictions. If nourishment is offered to him, he seizes upon it, with avidity. His nurse explains that it is difficult to appease his appetite, within the bounds of safety. He is eager to eat, because he is hungry, and because it gives him something to do. If too weak to move himself, he is desirous of being moved. Physical activity soothes his anxiety. Look beyond the sick man before you. Forget his pneumonia, with its array of orthodox symptoms, and iodine will occur to you. Iodine, with its glandular enlargements, and muscular atrophy, with its conditions of low cachetic debility, its slow suppurative processes, and its dyspnœa. Unlike the hepar patient, this case craves the cold air, and is particularly unhappy with any covering about his head. In croupous pneumonia, at the beginning of the plastic stage, iodine may help you, or in the third stage, when slow suppuration ensues, without marked fever, this remedy should be considered.

The iodine restlessness is a key note, and may send out a "feeler" towards arsenicum, but the arsenicum restlessness is prominently tinged with alarm, which is more mental and imaginative.

Another patient will give you an illuminating particular, when he bewails the *stitching, sticking* character of his chest pains. He is uncomfortable in any position. His distress is well nigh continuous, so he dreads to move. Study his face, and you will often see a peculiar puffiness above the eyes, filling out the brows. He will tell you of his disturbed sleep, of his paroxysms of dry hard coughing at three o'clock in the morning, but by this time, you are hot on the scent of Hahnemann's great anti-psoric kali. carb., a sheet anchor in many cases of ulcerated lungs. If you see kali. carb. watch for another of its peculiar symptoms, which reads, "sweats on the upper lip, dur-



ing sleep." A record of these apparently trivial often unexplainable idiosyncrasies of a drug, smacks of no scientific attainments. They carry no backing of proven pathological findings in any diseased state, rather do they sound at times, like the superstitious babbling of folk-lore, or old mother's medicines; but it is well not to forget that the greatest truths in the physical universe have often come to us thus humbly disguised. The true student sifts his observations of nature's workings. He has a safe place in which to store what he does not understand. Moreover, pathologists need sometimes, to be reminded that the most striking *particular* in a diagnosis of any given case, is frequently a point of minor significance, when we as homœopaths, seek to prescribe for the patient.

However, having administered kali. carb. to our last pneumonia case, we are interested in a near relative of this famous remedy. So closely allied are the symptoms of kali. carb. and kali. nit, that undoubtedly the virtues of the latter drug are, upon occasion, lost to the patient that called for it. The text explains that excessive heat and thirst, far beyond what we found under kali carb. is a point of differentiation. The patient complains bitterly of dyspnœa. A careful physical examination, now allays our apprehension. This is an instance, where the victim is not so bad off as he thinks he is, or as he appears to be. A copious sweat, or a hemorrhage will relieve his difficult breathing.

We want to tread lightly when we enter the room of our next patient. A very nice balancing of power must take place here, if we are to win out, in this case. He is not a promising looking sick man. We at once perceive the extreme seriousness of his condition. If we take up the nurse's chart, we find that our patient apparently sleeps into fits of exhaustion. A most distressing cough arouses him, if he drops off to sleep. He retches and gags feebly, over the tough, greenish, mucopurulent matter that fills his throat. He grasps at his throat, to free himself from any constriction of garment. This, of course, is that monarch of man's left side, lachesis, deep acting, process-changing, blood-disorganizing lachesis, with its ear marks of the crawling, sluggish, venomous, loathsome creature, from which it is derived. Perhaps nothing could have averted this miserable slump on the part of our patient. We may now tag the condition, typhoid pneumonia with threatened gangrene, and lose a night's sleep, while we ponder over

the difficulties, that beset the pathway of the humble homœopathic prescriber. But, whatever we did, or didn't do, in the beginning, if we see lachesis at this juncture, we may indulge in a somewhat more cheerful forecast. This remedy has a remarkable way of flirting with the undertaker. Down, down, sinks the case that it covers, then the tide may turn, and the fight is slowly but surely won.

In examining the sputum of another baffling case, we may be struck with its jelly-like consistency, with the little dots or points of blood showing in it. As we watch, we take cognizance of the shallow breathing. The patient seems too tired to breathe. We can scarcely detect any movement of the chest. Oncoming cyanosis is marked. The whole economy is slowing down. We look at the bluish pallor of the face. As the nurse administers some fluid, we hear it roll audibly into the stomach, at the same time the patient may be seized with a suffocative spell, assigned to the heart, and induced by sitting up. The condition is serious. Indeed, paralysis of the lung may be on the way. At this point, laurocerasus, a medicine which contains Hydrocyanic Acid, occurs to us. We appreciate the deadliness of the medicine in its crude state, we are able to perceive the kind of depression in the case before us; Homœopathy, and the homœopathic preparation of medicines alone, may juggle with these two forces, and the patient, and the doctor, and homœopathy come out on top.

It is a mal-treated or neglected case of pneumonia, which next engages our attention. Perhaps it has already passed into the typhoid stage. We immediately observe that the whole patient is profoundly affected. As we search for particulars, we hear that this is a weeping patient; that he dreads to be alone, and is generally cross and irritable. We find the right lung to be affected, while his cough is so painful, that it involves even his head, and stomach. It is a deep cough, and sounds as if he dislodged whole mouthfuls of lung, with the stringy, rust-colored sputa. We find this patient worse from four o'clock, on to eight in the evening. He wants to be uncovered. The lungs are fighting pitifully for oxygen, as the fanning of the ali-nasi reveals. If you offer him nourishment, he shows some animation and gives you the impression that he means to take all you will give him. A sip or two, however, fills him up. His craving has vanished. These symptoms are classical. In days gone by, lycopodium was a harmless infant

powder. It was Samuel Hahnemann's genius that placed it where it stands to-day, a giant among our anti-psoric remedies.

Two men may be holding a consultation over our next patient. It is a case of hepitzation of the left lung. The pains are sticking in character, and extend through, from the upper part of the chest to the left shoulder blade. The cough is described as tickling, and is worse in the morning. Both the cough and the tickling are better in the evening. One man suggests kali. carb. His colleague hits on myrtus communis, and myrtus has it. Kali. carb. has sticking pains in the lung, but they do not refer so definitely to the back of the scapula, and they are right-sided. A small difference, but some successful prescriptions hang on just these little points of differentiation.

Armed with a history of past gonorrhœal attacks, we approach another patient, with as open a mind as we find possible; for this case of complicated pneumonia plainly rests on a sycotic base. When, however, we discover that dampness, in any form, is a veritable red strand in the list of this patient's aggravations, we may seek our vial of natrum sulph. Subsequently we check off a number of confirming indications, notably, the inexpressible agony in the chest, which was a feature of the acute stage, the sticking pains that run from the abdomen to the left side of the chest; the expectoration of thick, ropy, slimy, yellowish green mucus, or at times blood streaked which coagulates slowly. The weak, all gone, empty feeling in the sore thorax, is so pronounced that the patient holds his sides when coughing. If we investigate further, we will doubtless run amuck of not a few constitutional symptoms, which we can arrange around natrum sulph.. The diarrhœa, for instance, is very guiding. It is an early morning demand. The patient will tell you that when his bowels are disturbed he must always hasten to the toilet the moment he stands on the floor in the morning. Then we may unearth a history of old asthmatic attacks brought on by any change from dry to damp weather, or from working in a damp cellar. Natrum sulph. will help these people.

The individual which I now propose to present is very typical. In youth and age we see the disproportionate development and nourishment of mind and body. It is therefore, a slender, stooped, frail looking patient, with the fair complexion that goes with red hair. She has a look of ethereal transpar-



ency that is augmented by a general appearance of physical weakness and lack of stamina. She will tell you that with every little cold she runs into an attack of bronchitis. Her chest feels constricted, and she wishes that you could remove the sensation of weight from her chest. Her whole respiratory tract is raw and sore. Her cough is dry, and constant, and seems to be stimulated by a tickling in the throat pit. If she goes further into her manifold physical distresses, you will be told of terrible sensations of weakness and emptiness in the stomach, especially at ten A. M. She will mention that she often awakens hungry in the night, and feels that she must eat, to overcome the faintness that seizes her. If she has diarrhœa, an attack will come on as soon as anything enters the rectum, when the bowel discharge will be profuse, pouring away as from a hydrant. In acute illness, the anus remains open, and the stools are involuntary. She is always worse in the evening. She cannot lie on her left side, or her back. Many nervous fears will be described to you, especially the ill effects of thunder storms.

Of course, we know our remedy for this individual to be phos. but so much has been said regarding the unwisdom of prescribing phos. under certain conditions, we should at least give these warnings a respectable hearing. Hahnemann says, "Phos. is a most powerful anti-psoric, but it can seldom be used with advantage, when the genital organs are weak, or when the sexual desire is depressed, or when the menses are delaying, or when the vital powers are weak and exhausted." Farrington says, "Be certain that it is the remedy, and do not give it too often, or you will hasten the process you are anxious to avoid." Rummel says, "Give a dose every fifteen days."

What then, shall we do with a case presenting the foregoing outlined demand for this remedy? I believe if we study our patient and find with a certainty that is as absolute as we are capable of comprehending absolutism in homœopathic prescribing, phos. may at proper intervals be given. These warnings apply only to cases of chronic pneumonia.

We will next interview a patient who is a near relative of the Irishman, who said that the most uncomfortable part of an attack of grip occurred after you got well. The patient of psoric diathesis, who is now signalling for Hahnemann's great remedy, psorinum, has been pretty sick. He has had, we will say pneumonia, and although the acute attack has subsided, he

protests that he has not recovered his health. He has no appetite, is full of forbodings, feels weak and uncertain about everything, and has no vital heat. He coughs some still. This is dry and hacking, or if he is able to raise anything, the mucus is greenish and very offensive, like everything else that he passes. His breath is short, and his general outlook very forlorn. The indefiniteness of this train of symptoms, possibly may lead you to prescribe sulphur. Remember, however, that the failure of sulphur to act is another spoke in psorinum's wheel. Psorinum will cheer this gentleman up, and restore his lost faith in doctors.

Our next patient will come to your office, and tell you about a sore spot in his chest. He has been down with pleuro-pneumonia, and his distress is caused by adhesions. He feels a constant inclination to breathe deeply, and rid himself of the distress. Read up *ranunculoides* bulb. and see where it applies in such a *sequalæ* as this, or if you have a case of intercostal rheumatism, with a sore, bruised feeling in the chest, think of *ranunculus* bulb.

In studying these obscure and non-yielding cases of protracted pneumonia, it is frequently necessary to leave the beaten track of the usual therapeutics, and gather in every observable point of divergance from the patient's normal well-being, with the sanguine hope, that even the most insignificant fact may be a "symptom" that will ultimately fit in, as we piece together our "jig-saw puzzle" of the indicated remedy.

Again I desire to emphasize the paramount importance of analyzing the patient first, and not his pathology in these unhappy conditions. Our friends of the other school are past-masters in following the different stages and states of pulmonary involvement, from the viewpoint of histology and pathology, and I deem it quite as important for the homœopathic prescriber to be able to detect, say, fluid in the thorax, and kindred danger signals, with all the nicety and precision that he can command, but let him assign these procedures their proper place in his conduct of his case. If they apparently drop out of sight in his zest to cure his patient, their disregard need not imply that this follower of Hahnemann will any more permit his patient to drown in his own fluids, than he would look on and see him drown in the Atlantic while he figured out what kind of a life preserver would be proper and adequate to throw to him, providing he could find just the right size.

We are also able in following the effects of our remedies to make a pretty sure prognosis, as we measure the periods of reaction to these medicines. A progressively shorter period of reaction following each administration of the indicated drug, shows that the odds are against you. In this study then, of the special and peculiar symptomatology that any particular patient exhibits, suffering from chest troubles, we are obliged to get down and literally dig into the case, while we keep our pathology within easy reach.

Take a patient whose bad evening cough is followed by copious loud eructations. Notice the hectic flush on her face, Look back, and perchance, remember that this same woman has long been a victim of periodical sick headaches. Reach for your *Materia Medica*, and refresh your memory of *sang. can.* It is a remedy often indicated in the second and third stages of pneumonia.

Those of us, who have been in active practice a few years, feel that it is often but a test of which one can talk the most and the fastest, the doctor, or the patient, when it comes to registering a case for the king of anti-psorics, sulphur. The patient will get in about his burning feet, and the doctor will tell him about the miserable heat on the top of his head; the patient will describe his frequent weak spells, and the doctor will think of the general physical obnoxiousness of the poor old soul, who may be threatened with phthisis, because his old pneumonia is still doing business. Sulphur has marvelous powers of letting in rays of "sweetness and light," just as it has been credited with sometimes hastening the irresolution of physical inaction into the resolution of death.

Sanitation and the drainage of marsh lands has had much to do with the arrest of malaria, about which we heard so much a few years ago. Our old friend, the mosquito, is now in line for extermination, with the belief that his going will add to the sum total of human happiness in more ways than one. Dr. G. W. Bowen stands sponsor for a homœopathic remedy called *malaria off.* He lived on the Wabash river at that time, a malarial region, and for many years treated hundred of patients suffering from malaria. The question naturally arises, what has *mal. off.* to do with pneumonia? Again, I answer, we are not treating pneumonia, but people who have, or have had pneumonia. *Mal. off.* will bring about reaction after la grippe, typhoid, or chest troubles, when arsenic appears indi-



cated, and fails to act. After the establishment of this reaction, your arsenic may prove to be the curative remedy.

It is reported that the marshy districts of South America, Africa and Spain have arrested and cured phthisis. How often have cases of phthisis been treated for malaria, until the cough and the bacillus have told us of our mistake? This remedy, given in the insipidity of this disease, might have modified a diagnosis, perhaps, by curing the patient.

Briefly the symptoms calling for malaria off. are headache, as though the head would burst, throbbing pain in the whole head, with vertigo, and a sensation of confusion. The tongue is coated white with a brown streak down the center. Your patient vomits everything. You will find shallow breathing, apparently from languor, with a desire to breathe deeply, and occasional sighing. There may be constant hacking cough, or half minute guns when talking or turning over in bed. The patient is restless and nervous. Where there is a history of active or suppressed malaria, this remedy may bring about a reaction. But malaria, like its fellow nosodes, only palliates some cases, and cures a few.

However, the nosodes, medorrhinum, pyrogen, syphilinum, and tuberculinum, are a noteworthy group, each one of which is deserving of careful investigation, and unprejudiced study. They have received careful provings, and are in every way entitled to a place in our materia medica. I will give a few of their general symptoms. Dr. H. C. Allen has given them full amplification in his book on the nosodes.

Medorrhinum, as a medicine, is indicated in children, who were born apparently healthy, thrive for a few months, and then for no observable cause, emaciate, become marasmic, or develop asthma. It is also useful for sterility in women, who suffer from chronic ovaritis, pelvic cellulitis, fibroids, etc., for be it remembered, the gonorrhœal poison has caused more race suicide than any one thing.

There may be trembling at the pit of the stomach, with a sensation of agonizing sickness, and sinking. Nervous, hysterical symptoms abound. The patient wants to tear something away. He has a queer choking in his throat, which is caused by weakness, or spasm of the epiglottis. His larynx is occluded, so that no air can enter. *He obtains relief by lying on his face and protruding his tongue.* We hear a great rattling of mucus, but this appears too low to be reached by hard

coughing, unless he lies on his face. The chest feels sore throughout. *Medorrhinum* may be thought of for cases of defective reaction after pneumonia, where there is great burning in the lungs. In point of fact, this nosode runs the whole gauntlet of sensations. Your patient may tell you that he has a remarkable feeling that there is a cavity where his heart ought to be; that his heart flutters most unpleasantly; that a pain runs from the apex to the base. That he must keep his feet moving; that these same feet burn, and if he had a nurse, he'd have her fan them. If he thinks of his troubles, they increase. Heat is unbearable, and from daylight to sunset are the hours of his special torture.

*Pyrogen*, a product of sepsis, is indicated in cases of septicemia from whatever cause, when the seemingly indicated remedy fails to relieve, or permanently improve the case. It has the bruised feeling of *arnica*, and *bap.* with rapid decrease of strength. There is great restlessness, the patient must move, to mitigate the soreness of the parts. The tongue is flabby, or fiery red, and there is a sweetish or pus-like taste in the mouth, with a terribly foetid breath. You may have persistent vomiting of offensive matter, and carrion-like stools. The pulse is abnormally rapid, out of all proportion to the temperature. In neglected cases of pneumonia, *pyrogen* may come in, where there is cough, night sweats, frequent pulse, and a sore chest, covered with purple spots. Expectoration, consisting of large masses of offensive phlegm from the larynx, which mucus is so thick that it threatens suffocation, suggests *pyrogen*. Or you may find a cough with rusty sputum or bloody sputum, both horribly offensive. With this condition, complete inertia of the bowels may complicate matters. The stools are foul, and in the form of small black balls, the size of olives.

*Syphilinum*, like the other nosodes, may be needed to arouse the vital force. Do not give it, because you have a syphilitic history, but give it, in spite of this history, if the symptoms agree, though to be sure, a history of syphilis strengthens your case. The cough and the sputum are not so characteristic, as some of its peculiar symptoms. The aggravation from darkness to daylight, marks *syphilinum*. The syph. patient dreads the night. His pains, cough, and exhaustion are all sure to be worse at night. He awakens exhausted out of a troubled sleep. He has a lancinating pain from base to the

apex of his heart, at night. You will remember, med. has a somewhat similar pain, but med. notices it prominently in the day time, and the direction of the pain is oppo. If the syph. subject is a victim of asthma, he will have a spasmodic bronchial asthma, coming on only at night, after he lies down, or during a thunder storm. His expectoration is thick, and purulent, but oddly enough it is quite tasteless. This is a key note.

Tuberculinum is noted for its ever changing symptoms. It has an affinity for ailments affecting first one organ, and then another, lungs, kidneys, joints, liver, and taking a turn. Its pains begin suddenly, and cease as suddenly. The tubercular patient is forever taking cold. They never know where or how they take cold. We are all painfully familiar with the physical make-up of these unfortunate people. For the special symptoms and the brilliant picture which calls for tuberculinum in its fitting homœopathic application, I must again refer you to Dr. Allen's book. The remedy has a wide sphere of usefulness, and is worthy of serious attention.

If we observe the progress of present day medical science, we cannot fail to be struck by one great fact. Whenever the allopathic school of medicine starts out on a fresh scent of research work, it invariably finds some old truth of homœopathy in at the "finish." As students of Hahnemann, we may not at first recognize anything belonging to us in their new "trophies," but time clears away our confusion. If it is a "fox tail" at all, the laws governing the homœopathic administration of medicine to sick people, must somewhere be a part of the "brush." Enthusiastically do our friends ride forth, on their praiseworthy investigations. We do not have to go so far afield, but we do need to redouble our efforts to master the use of the tools already within our grasp, and at the same time keep hopefully in the light, awake to see new truths further on.

#### DISCUSSION OF DR. KRICHBAUM'S PAPER.

The discussion of Dr. Krichbaum's paper was opened by Dr. Wallace McGeorge, of Camden, N. J.

DR. MCGEORGE.—Many of the remedies mentioned by Dr. Krichbaum are remedies we would not think of in pneumonia at all, but every one of them has been useful and has cured cases. He speaks of eighteen or twenty.



Let us take *natrum sulph.* We would hardly think of it in pneumonia cases. We have used it in diarrhoea, early morning diarrhoea, but it has a sphere of usefulness in other cases. It will cure your consumptive patients if they are troubled with early morning diarrhoea, not only pneumonia cases, but consumptive cases. You can save pneumonia cases that are apparently going to die. Another is *sanguinaria*. He gives us a nice picture of *sanguinaria*. It brings back to me a scene that occurred in my own home about fifteen or sixteen years ago. My oldest boy was dying with pneumonia. He had pneumonia and heart disease, valvular disease of the heart, in connection with it. I had three homœopathic physicians see him, among them was the then President of this Society, one of the best physicians we had in Camden. Finally he came to me and said, "My brother, I am sorry, but you must prepare to lose your boy. He cannot get well." It may not seem polite, but I got that doctor out of the house just as quick as I could. I went down and got out my materia medica, and I made up my mind that *sanguinaria* was the remedy. I gave it to him and he is alive to-day. I would not give him up. We must not give up our cases. When we have a bad case we must stick to it. We ought to fight these cases. *Sanguinaria* saved that boy to me and his friends.

Another is *apis*. *Apis* is not a remedy we would think of, but it is fine. The indications that are given for it are so good. It is rarely given in pneumonia, but in so many other cases. I want to thank Dr. Krichbaum for sending me his paper to read. Since I saw it I had a very troublesome case, and I gave the patient *apis*. It helped me greatly.

Another is *laurocerasis*. It seemed to bring the patient right before us. That is what we want. We want to draw the picture so well that you can recognize it. We want to fix it so that you know what the remedy is. That Dr. Krichbaum does. I think it is such papers as that that we come here to hear. We come here to learn. We want to be better homœopaths. We want to be able to go to the old school, who say you cannot cure pneumonia, you must give it this serum and that serum. if you don't the patient will die,—we want to say, "We don't give them the serum, but they don't die." Of course, sometimes they die in spite of you, but the great majority of them live. It was the success of the early homœopathic physicians in the treatment of pneumonia in Germany many years ago that gave homœopathy its start, and it is just as good to-day in the treatment of pneumonia as it was one hundred years ago.

DR. RABE.—I would like to discuss Dr. McGeorge's paper, if you have no objection, and in part, this paper of Dr. Krich-

baum's, which unfortunately I did not entirely hear. I regret that I was detained this morning and unable to get here in time to hear these papers. I had the pleasure of reading Dr. McGeorge's paper on the way out, at the eleventh hour. Unfortunately conditions in New York have been such this spring, what with private work and particularly college work, I have had very little time to do anything, hardly time enough to finish my own paper, but I want to say not only words of commendation in regard to both papers, (because both papers are deserving of the greatest commendation), but I want to express a few thoughts that come to me as a teacher of materia medica. I think these papers emphasize the necessity for teaching homœopathic therapeutics, provided that such therapeutics are properly taught, and taught as is indicated by these papers. Now, as you all know it is a common practice in our homœopathic colleges for those teachers who are teaching diagnosis and teaching diseases to merely point out a few homœopathic remedies which are or may be useful in the disease upon which they happen to be lecturing. That kind of teaching is rather a dangerous thing, because it leads to empiricism, and frequently to failure. Not only that, but it limits in the mind of the student the choice of remedies for a given disease to one of a very few, and this of course is a mistake. The specific disease only is presented in the department of materia medica where remedies are lectured upon from the standpoint solely of the materia medicist and not from the standpoint of the therapist. In other words, symptom pictures should be pictures where the symptoms are presented, with reference to the remedy. This is the proper way.

Then it has this disadvantage, that the students sometimes complain that while they have heard the various remedies lectured upon, at the same time they know little or nothing about the specific indications for these remedies, in any given case of disease. So you see it comes to my mind especially that after all what we need in the homœopathic colleges is homœopathic therapeutics properly presented. This is a problem which we in New York are taking up, and which I hope we shall be able to work out, through the chair of practice and the chair of materia medica.

I did not hear all the remedies touched upon by Dr. Krichbaum, but from my own personal acquaintance with him I know pretty well what his indications are and what remedies he touched on.

Dr. McGeorge has beautifully presented the indications for the usual remedies in infantile pneumonia. There is really no discussion possible because there is nothing to say. But he

speaks of lycopodium, and gives the indications for lycopodium in infantile pneumonia. And they hold good for pneumonia in adult cases as well. But there is something I want to bring to your minds, and that is this: the peevishness or crossness of a lycopodium child, especially upon awakening, is to be compared with the same thing in cina. Cina is exceedingly cross and peevish; and cina, chamomilla and antimonium crudum are always to be compared. So far as cina and chamomilla are concerned, there is this differentiation, that in chamomilla, the urine is scanty, very strong and dark, in cina the urine is profuse and usually light in color. Then the cina child is exceedingly cross on awakening. That is an indication touched upon by Dr. McGeorge, and is a good one. Cina, however, wakes up with very red cheeks.

Ferrum phos. in infantile pneumonia, I have found very frequently to be a remedy of the greatest value, especially in the early stages, where hyperpyrexia is present, where it is one of the indications, where the child is more or less dull, rather apathetic, not to the degree in gelsemium, with pulse accelerated, but midway between lycopodium and gelsemium. Of course expectoration in that case is to be found. It is present in any case, any way, but in those circumstances in the early stages it will be found and is an indication of aconite or lycopodium or gelsemium.

Ferrum phos. is a remarkable remedy. I have seen it reduce a temperature from 105 to almost normal within fifteen to twenty hours.

I do not know whether chelidonium was touched upon or not, but I have had some excellent experience with chelidonium in pneumonia of the right lower lung where we get the characteristic symptom of pain in the region of the right lung, especially of the lower angle of the right scapula, where the pneumonia takes more or less the form of what we call the bilious type, where you find a limited amount of fever developed, there is bile absorption and stains on the skin and conjunctiva. In those cases chelidonium is a remarkable remedy, in cases which are slow in resolving.

Iodine has been mentioned. There is nothing further to say about it. I merely want to give this experience with one of our men. Dr. McMichael told me that in his early practice he had a case which puzzled him considerably which was referred to him by the late Dr. Lavell. He looked the case over and suggested iodine, and Dr. McMichael had no iodine with him and could not go back to his office; in fact, I believe he did not have it in his office. He took some ordinary tincture of iodine, poured an indefinite amount in a glass of water, stirred it up



and ordered a teaspoonful every two hours, with remarkably quick response and recovery. And he told me that since that time he has confined himself to the use of the tincture, used it for years, and always with good results, and without causing restlessness. Iodine may cause a good deal of thirst, but not the restlessness of aconite.

I agree with those who say that these papers are most helpful. These are the papers that we need in our societies.

DR. KRICHBAUM.—I want to say one word with reference to ferrum phos. Don't forget ferrum phos. when you think of bryonia. In inflammatory rheumatism it will do you good to think of it. If bryonia doesn't work, try ferrum phos.

## INDICATIONS FOR REMEDIES IN PNEUMONIA.

BY

F. P. MCKINSTRY, M. D., WASHINGTON, N. J.

ACONITE is not very frequently indicated and then for a short period only. It best suits nervous apprehensive cases, with fear of fatal termination. Great restlessness and full rapid pulse.

Verat. Vir. is the most frequently indicated remedy in the first stage. High temperature, full bounding pulse, flushed face, but with lack of the restless nervous state. Rather somnolent and disposed to lie quietly.

Fer. Phos. should also be considered in the initial stage. Old people, cases of the sneaking variety, and secondary form, where the chill is not well marked. Cases that exhibit soft pulse and lack the sthenic condition of frank pneumonia.

("Expectoration of pure blood in pneumonia") is a clinical symptom emphasized by Boericke.

For the second stage, our first thought is Bry. Alb. and objective and subjective symptoms usually verify the choice. If you will allow it, an extract from a paper on Bry. read before this Society two years ago will illustrate my point: "As shown in post mortem appearances in the lower animals dead from the effects of the white bryony, the mucous membrane of the respiratory tract becomes congested and even highly inflamed. The lungs become so profoundly affected as to sink in water and the pleural sac is inflamed."

"Among the provers 13 developed pain in the chest, in 7 the chest pains were stitching, in 6 pains were worse by movement of chest muscles, and in 3 by respiration, 8 provers had cough.

"These subjective symptoms in connection with the pathological findings referred to, establish a pretty strong case of drug affinity in diseases of the lungs and pleuræ."

The time honored indications for Bry. are so familiar that I will not rehearse them. Evidence of the value of Bryonia is not lacking in eclectic and old school literature.

Phos. is another remedy for careful study. It is interesting to recall the fact that Phos. was first used by Fleischman, of Vienna, in the Leopold Stadt. Homœopathic Hospital, with a mortality of 5 per cent. in 377 cases.

Tessier, of Paris, treated practically all cases with bryonia during the day and phos. at night, and his success was so noteworthy as to attract the attention of his old school associates.

Of course, it must not be overlooked that expectancy was more successful than the methods of treatment then in vogue, but still I believe it is a matter of record, that the treatment of Fleischman and Tessier gave better results than the expectant method which had its advocates even at that day.

In addition to the symptomatology, Baehr adds the following post mortem results in cases of poisoning by phos.: "Severe hyperæmia of single lobes; more or less extensive hepatized portions of the lungs, and according to Bibra, distinct tuberculization of the exuded fibrin."

The precise indications for phos. seem a little hard to define. The general appearance and building of the patient, the type of the disease, i. e., the case not doing well at the time when there should be some sign of improvement; typhoid symptoms, oppression of the chest, scanty expectoration, collateral œdema. Ringer and Blair of the old school both testify as to the value of phos. for these indications.

It is very important that a fresh preparation of phos. be used and should not be given in water, unless each dose is dropped separately. A very convenient way of administration is to saturate discs or pellets with the remedy.

Ant. Tart. Little need be said in regard to this drug. Its well known indications of loud rattling cough, with little expectoration, difficult respiration, drowsiness and tendency to cyanosis are familiar to us all.

It is interesting, however, to recall that Hughes says of the

proving of ant. tart. made by Dr. Molin, of Paris, in 1847: "Now it is quite clear that in this proving of tartar emetic Dr. Molin developed in himself an incipient pneumonia." Ringer and Blair also have attested the usefulness of ant. tart. in lobar pneumonia and capillary bronchitis.

Ammon. carb. is a remedy to be compared with ant. tart., Farrington says, "It is its nearest analogue," and his indications are as follows: "You will find ammonium carb. indicated for somnolence or drowsiness with rattling of large bubbles in the lungs, grasping at flocks, bluish or purplish hue of the lips from lack of oxygen of the blood." With this symptom complex we usually have a falling heart and so another very important indication for ammon. carb. Owing to the extreme gravity of this condition and the similarity of symptoms, I must confess I usually alternate ammon. carb. and tart. em.

#### DISCUSSION OF DR. MCKINSTRY'S PAPER.

DR. CORSON, OF OCEAN CITY, N. J.—This is a homœopathic conference, and we are here to hear about remedies. There are some other things that you probably frequently use in pneumonia. We see an antiphlogistine advertisement here and there. What I would like to speak about is how far the men generally go in fresh air treatment of pneumonia. That is a thing some people take a very decided stand on, and put the patient out of doors, using practically the same methods as in any tubercular case. I would like to know the general feeling among the men. I feel that the fresh air treatment is of decided advantage in these cases. In the cases I have had I open the window, even in cold weather. They seem to breathe easier, certainly the principle of oxygenation, as far as possible to get it, is increased by free admittance of fresh air. It is a question on which a young man takes some chances on himself. Some people think that fresh air is not good.

DR. KRICHBAUM.—Dr. McKinstry wanted to know the differentiation between ammonium carb. and antimonium tart. Ammonium carb. is more general. We find the patient with an alternation of hot and pale face, pallor. They do not have the sensitiveness to touch, and the mental irritability of antimonium tart, but you will find the ammonium carb. patient is also stout, flabby, fat, similar to calcari, or cali. carb., and many others.

DR. ATKINSON.—Dr. Corson has spoken of cold air treatment. The old school results with pneumonia, their successes, have increased enormously in the last few years. The increase



was marked after they stopped bleeding the patients. There was a further increase in their success when they stopped putting poultices on. There was another increase in their success when they stopped drugging the patient. There was another increase in their success when they stopped freezing the patient. There was another increase in their success when they began to stimulate the patient with very small doses of stimulation, as strychnine, and a little digitalis, very small doses, for them to give, but their successes have been marked just along about those lines. But they have had very much more success since they have been using cold air treatment. In my own experience this winter I have had more cases of pneumonia to treat than in four or five years in my practice. We have had a fair epidemic of pneumonia down in our section, and thus far they are all above ground. With all those cases I have persisted in absolute cold air treatment. I covered the patient with a sheet only, and wrapped the feet up in blankets, with a hot water bag to keep the feet warm. They would get cold. And I rarely was called upon to use stimulation, using the remedies as they seemed to be indicated, opened the windows wide, and in nearly every instance I had the fight suggested by Dr. Corson. People said, "Well, if the patient has pneumonia, you must keep him warm," but I succeeded in getting the nurse and possibly the friends of the patient to co-operate with me in keeping the room cold, so cold sometimes that the nurse, whoever it might be, was compelled to wear her winter clothes and winter coat in the room with the patient. In a great many of them I was able to get the crisis in five days. In none of them was the crisis delayed over eight and one-half days. I think I had on hand five cases of pneumonia at once, which in our section is remarkable, to have on hand at one time in one little section. But we had a great many cases and all have come out all right so far. One patient was seventy-two years old, and I had them run down as low as two and one-half years of age: but all had the same general plan of treatment.

DR. KRICHBAUM.—I think you would have to distinguish your patients,—take an old man, very susceptible to cold, and put him in a cold room would be suicide. As a rule, give them plenty of air and lots of it, but I would not put an old person under that treatment.

DR. MCKINSTRY.—I want to say that my paper was not very long for two reasons. I was to treat of only ordinary remedies in ordinary pneumonia. The remedies to be used in irregular cases were to be taken up, under the division of labor, by other persons; and I wanted to make my paper practical and not theoretical, give you something in which I have had prac-

tical experience. For those two reasons my paper was brief. I know a number of remedies were left out with which the rest of you are familiar.

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## PNEUMONIA, ITS LOCAL TREATMENT, CARE AND HYGIENE.

BY

FRANCIS MCCONAUGHY, M. D., SOMERVILLE, N. J.

I am aware that each physician has his own pet treatment for pneumonia and many of those who listen to this epistle may differ with my views and my methods, and being as they are practitioners of the only school of medicine for the successful treatment of pneumonia, each one feels that he has about as good success in the cure of this disease as is possible for an average human being to have. This is not intended to be an exhaustive treatise upon the subject, but simply a practical one. I want to say too that if at times my style smacks a little of kindergarten simplicity it is no reflection upon the brain-end of my hearers—there are no references to allusions.

In these days of germs, bacteria and bacillicusses it behooves us to adopt such methods as will prevent the entrance into the system or contact with the body of these destructive gormandizers and multipliers which are omni-present and are simply awaiting, not an invitation but an opportunity for entrance into a favorable field of operation.

When we consider that pneumococci are found in the upper air passages of many absolutely healthy persons and accepting that the only thing necessary for the development of pneumonia is the presence of pneumococci in the alveoli of the lungs, it simply remains for favoring conditions to cause a transfer of the germs to the air cells where they start up their multiplication and irritation and exudation.

It has been many years since we first learned that good health is the best preventive against any disease and anything which tends to lower the vitality and decrease resistance, such as alcoholism, continued exposure to cold or inclement weather, excessive fatigue, or anything which depresses the heart's action, paves the way for the propagation of the pneumococci and for the easy development of pneumonia.

The patient should be put to bed in a quiet, well aired room

in one of the upper stories, if possible, away from the street noises and distant from the interpretation of familiar sounds about the house. They should have freedom from everything tending to worry or cause undue activity of the mind in one who not only has a fever, but is also short of oxygen and consequently below par in brain power, such as visitors, household problems or a talkative or over-officious nurse.

I feel very sure that I have seen at least one patient, a typhoid-hepatic pneumonia, killed by a trained nurse who everlastingly persisted in cleansing the teeth, scrubbing the tongue and bathing too frequently, beyond all reason and judgment, a patient whose low ebb of vitality demanded less interference and more rest.

Plenty of fresh air should have constant ingress and should be well warmed to a temperature of 65 or 70 degrees, and it should not be cooked dry by steam heat, nor should it be second hand from some garbage pile, nor third hand from a cabbage-and-onion air shaft. The exudation is softened and expectoration made much easier by rendering the air of the room moist through the aid of a pan of water on the stove, or the radiator, or by towels wrung out of boiling water, or by steam.

Locally heat is indicated to help the softening process and to assist in relieving the pleuritic pains. Hot bran bags or hop bags have the merit of lightness and I might add freedom from the abominations of wet applications, with which all of us are familiar. Only in slow or delayed resolution do I ever use antiphlogistine, although I have used it a number of times with benefit. In obstinate cases several times have I used that other abomination, the old-fashioned hot onion poultice, with marvelously prompt results in softening the obstinate consolidation which seemed to have no notion of vacating. (You will remember when the small boy was asked what a lie was, replied, "An abomination unto the Lord, but a very present help in time of trouble.")

If the pains are quite severe, sometimes a fairly snug binder will add to the patient's comfort by limiting the motion of the chest and will prevent the sudden awakening from a salutary nap by the pain of an unconscious inspiration. If the pains are very distressing a hypodermic of morphia submerges the pain and at the same time slows the respiration and improves the circulation in the affected part.

The bowels should be kept free, not only to assist in the



elimination but to avoid depressing the action of the heart already overworked, and to prevent further congestion of lung tissue. The salines such as rubinat, hunyadi and pluto waters are usually all that are required for this purpose, though in cases with high temperature, a high saline enema will clean house better and assist greatly in the reduction of temperature.

If the fever runs high with hot skin, much dyspnoea and patient is highly nervous, a sponge bath with tepid water will lower the temperature, soothe the sensory nerves and quiet the patient. When we consider that the capillaries can hold sixty per cent. of the blood of the body, the warm bath brings the blood to the surface, thus temporarily removing from active circulation sufficient blood to give the overworked heart a needed rest and will often produce a profound sleep for an hour or more.

Many physicians prefer an ice cap to control the fever and use cool sponging of the chest and sides, and if possible the back, for prompt lowering of temperature.

The expectoration should be carefully guarded that it may surely be destroyed. All discharges should be treated with Platt's chlorides or other suitable antiseptic before being disposed of.

The lowering vitality and toxins have put the digestive outfit on more or less of a strike, due to depraved enzymes. The diet during the fever stages should be liquid, milk being the best, if tolerated, a small quantity being given every two or three hours. Malted milk and junket give good returns for the amount of work done by the stomach. (I am reminded of when I was in college, twenty dogs were fed on Liebig's extract of beef, and twenty others given no food, those starved to death lived the longest. The amount of energy expended in digesting the beef extract—so nearly analogous to urine—was not offset by the nutrition it furnished.) Unfermented grape juice is a favorite of mine and is nearly acceptable because of its refreshing taste—patients suffering from lung and bronchial troubles usually crave these refreshing fruit acids. The juice of one orange and the white of one egg beaten together is a preparaiton nearly always relished.

Sometimes a stronger diet is needed in this stage, such as meat broths, beef juice, pano-pepton and egg nog. After the crisis a more liberal solid diet should be gradually included, but great care should be taken to avoid overfeeding. Great caution

should be exercised too in selecting a diet which will not ferment and thus hamper respiration. Slippery elm tea and gum-arabic water render the expectoration more easy and soothe the throat irritated by constant coughing.

Cold water should be given freely to keep the tissues full and to aid elimination.

I cannot agree with those who advocate stimulants throughout the attack as a routine measure, because they mask the patient's real strength.

I never prescribe them except when the indications point to their use, that is the dicrotic pulse or the rapid, weak, irregular compressible pulse, which usually comes late in the disease and always shows us we are up against it. I rarely use anything except brandy or whisky well diluted in four to eight parts of water, and these for a short time only, depending at this stage upon egg nog if a stimulant is needed.

Nitroglycerine is usually indicated in engorgement of the right heart as shown by cyanosis or venous congestion, fullness of jugular veins and a weak second sound. Strychnia, however, covers these conditions, too, as well as the weak heart muscle caused by the heavy load of toxins. The most desperate case that I ever succeeded in pulling through was given the combination of strychnia, digitalin and nitro-glycerine, every two or three hours. Craetegus will frequently take the place of all other stimulants if given in five or ten drop doses four times a day.

To compensate for excessive loss of respiratory surface as shown by cyanosis, dyspnœa, cold surface and feeble pulse, oxygen should be used and is called for when the respirations go above 40 per minute.

I feel satisfied that this commonsense treatment, with the indicated homœopathic remedy, properly handled, will rarely lose a patient from pneumonia unless there be also some other serious adverse contributing symptoms.

#### DISCUSSION OF DR. MCCONAUGHY'S PAPER.

The discussion of Dr. McConaughy's paper was under the care of Dr. Savoye, of Westfield, N. J.

DR. C. H. CHURCH.—I want to speak about two things. One is the point which Dr. McConaughy brought out. He said he did not give stimulants through the whole course of the

disease, but only when indicated. I think that is something to keep in mind, very strongly; do not give stimulants of any kind, I do not care what it is, if you can keep your patient in any other way, in any decent shape without it. If you have a weak patient and stimulant is given, you are not giving strength, but simply using the whip, taking from the patient the reserve strength which the patient needs to carry him through the crisis. I am not saying that you should not use stimulants once in a while, but I do want to raise my voice against the idea of using it except at the last ditch. I remember a case that my father had a good many years ago, not of pneumonia, but of hemorrhages of the lungs. The patient was having hemorrhages several times a day. The doctor said, "There is nothing I can do, he is going to die, and going to die quick. If you want to get anyone else, get him." He had been crying all the time for milk punch and he had been having it. My father was called in and he said, "Do not give him any more." He had one slight hemorrhage that afternoon, and that was the last one he had in a good many years.

Another thing I want to speak about is the high power incandescent light. Wherever you can use it you should have it. You will get a great deal of relief, and sometimes a great deal of benefit from it. I recommend a high power lamp, 500 power, but that cannot be used in an ordinary house, but if you can get 300 or even 100 candle power you sometimes will relieve the pain very greatly and help the patient. I have seen 500, when I was almost sure the patient was going to die with pneumonia, with a very high temperature, reduce the temperature about a degree in twenty minutes.

DR. MCGEORGE.—I wish to say one word in reference to the treatment of pneumonia patients, that is, give them plenty of air. If there is anything a pneumonia patient wants it is cold drinks, cold food, everything cold. There is a great deal to that, and there is nothing better than cold water. That was forcibly impressed upon my mind by the remark of Dr. Bunce, "Fever is fire; you put fire out with water. Pneumonia is fire; put the fire out with water." There is no disadvantage; it kills the thirst, lessens the fever, increases the action of the kidneys, increases the action of the skin, and gives all of the organs a chance to do something. I once had a case of pneumonia, sixty-four years old, and that man never coughed a cough, nor ever raised a particle, but he sweated it all out of his skin. We had to bathe him three times a day all over his body, and the water that was used was covered with slime, as if he had been steeped in it. We could not bear to sit in the room, it smelled so. But he made a rapid recovery and cold water did it. Of



course he had proper medicines also. He lived twenty-seven years afterwards, yet he was given up to die. Don't let us be afraid of it. It does not cost much. It is so good to give him the water. Let us use it. It is better than a good many things that are made to sell.

DR. CORNELL.—I want to say a word about stimulation. I think there is a place for stimulation in cases of pneumonia as well as in other cases. I think the mistake is made in giving the stimulant just because we have a case of pneumonia. But I don't think we have a right to use stimulants simply because we have diagnosed the case as pneumonia, nor allow our patients to die for want of stimulation when the demand comes. I think the time is when the patient needs it; when the heart is failing and it seems as though the patient might die unless something radical was done. That, I believe, is the time for stimulation. I believe at such times something should be administered like alcohol or stropanthus, something like strychnine, digitalis, or even nitro-glycerine,—but that is pretty near the last ditch. I remember an old lady some seventy-two years old, on whose case I was called into consultation with another physician. We practically gave this old lady up to die. I did not think she would live an hour. There was the minister in the house; he was praying for her at her bedside, and we were pretty near ready to announce her death. But we went back in the room and it struck us that this woman had not had any rest for two or three days,—three or four days—absolutely no sleep. Her pulse was irregular and weak and we administered a hypodermic injection of an H. M. C. tablet. I think you know what they are,—hyocine, morphine and cactine, put up by the Abbott Alkaloidal Company. I have used very few of them myself in my practice. I think it was in this case and in one case of obstetrics I used it. In this case I happened to think that I had one of those little tablets, and I thought of the small amount of morphine in it, and that this patient was greatly in need of sleep; and I believe that that tablet saved her life. She is living to-day.

DR. PERKINS.—Speaking of stimulation and pneumonia and elderly people especially, we had two patients, one seventy-eight years old, down with arterio-sclerosis; another eighty years old, also down with arterio-sclerosis. Both had a blood pressure of 180 or 190. They were both getting well of pneumonia when the heart began to fail. I thought that we must help them out. No digitalis, because the heart was weak. I thought of cratægus and glonoin. They did wonders. I simply used the five-drop dose of cratægus and one drop of glonoin,—simply something to tide over the crisis.

DR. RABE.—This brings up the old question—those who stimulate and those who do not. Dr. Perkins suggests glonoin and cratægus, Dr. Cornell, strychnine. In other words, you are casting overboard a rule of therapeutics which should be our guide. When we come to the point where we have nothing to guide us, absolutely no law on which to depend, empiricism comes to the front. I am not quarreling with the gentlemen who use the stimulant, but if your case had been well prescribed for, such stimulant will seldom if ever be necessary. I mean this without any reflection on other men as prescribers. Nevertheless sometimes they have missed the remedy. They are giving a remedy which they believe to be homœopathic to the case, which in reality is not so, because, if it were, the remedy would be sufficient to take care of the case, and stimulation would not be necessary. There are some exceptions to this; at least one, anyway, those cases which have been accustomed to alcohol. Those cases, I think all agree, need a certain amount of alcohol during their pneumonia. If they don't get it they will die. It is the same with morphine users. You cannot withhold the supply all at once. In the hospital practice we inquire whether these cases are alcohol users, whether they are alcohol pneumonias. Sometimes large amounts of whisky or brandy, whatever we may see fit to use, are used in those cases.

There is another thought that this paper suggests to me and that is the advance in the treatment of pneumonia, pointed out by Dr. McConaughy, and the thought that such advance has been along the lines of homœopathic principles. Dr. Church mentioned it also. It is pleasing to me. He mentioned onion poultices as an application which in some cases has proved useful. Recently I was interested in reading in one of our old journals an article by an old physician upon the use of onion and garlic,—*allium cepa* and *allium sativum*, and he mentioned the fact that they frequently used the remedies in pneumonia. *Allium cepa* produces wonderfully profuse coryza. There are undoubtedly cases—I have seen some—which have been *allium cepa* cases. Take, for example, a case exhibiting symptoms apparently of catarrhal pneumonia, where you have profuse coryza; with an exceedingly painful condition and rales worse on the left side, and with a brown watery discharge. That you would characterize as an *allium cepa* case, particularly if the patient desires cool air, wants the windows open. That is an *allium cepa* case. Frequently there is a good scientific basis for the employment of onion poultices, even though it is a very crude way of applying the remedy.

DR. BAILEY.—I would like to throw out a hint on something

that Dr. Church said. If you will use a Tungsten light you will get better results. The light does not produce as much heat and you can keep the lamp at the body for a longer time. You can increase or decrease the heat and you can give from four to six or eight times the light, with the same amount of heat. That light will carry the heat much deeper. A Tungsten lamp is much better than an ordinary carbon lamp.

DR. CORNELL.—I don't like the idea of Dr. Rabe putting me in the stimulating class. I much prefer to work the cases through without the use of stimulation. I must say I think a mistake is often made in using stimulation, but I don't want to say I don't believe in stimulation at all. I think Dr. Rabe is perfectly right when he says that often when we have to use these stimulants it is probably because we have not hit the homœopathic remedy, especially in my case, I know he is. But I wait until the last minute every time, and sooner than see my patient go out altogether without anything, I sometimes use a little bit, but not much strychnine. You put me in the strychnine class, but I would like to be put in the other class a little bit.

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### THE TEACHING OF HYGIENE TO THE AVERAGE CHILD.

BY

CHAS. F. ADAMS, M. D., HACKENSACK, N. J.

WHEN the founders of our Republic determined to establish in this land a government "of the people, for the people and by the people," they foresaw that unless they were willing to have re-enacted here the scenes of anarchy and bloodshed which had disgraced Europe and the rest of the world, the people, the lords of the country, must be educated. And so, for these reasons, and to ensure, so far as possible, a condition of social equality, they laid the foundations of our system of free public education which, more than any other single influence, has helped us to develop what we believe to be, in theory at least, the best government on earth. They believed that this was the one essential method by which to anticipate and prevent the intellectual, and so, to a large extent, the moral and political conditions which had proved stumbling blocks to other nations. The plans of our forefathers have been developed, step by step and year by year, until our public school system has grown to what it now is. During all this time both the originators of our educational plan and their various successors have tacitly conceded the truth contained in the old adage, "A



sound mind in a sound body." Practically, however, little has ever been done, until very recently, to obtain this most desirable balance; there has been endless instruction to obtain the sound mind, little or none to secure the sound body, and where the latter has developed, it has been rather by the provision of Providence than by the provision of man. Some passive recognition of the principle there has been in effort to restrain too ambitious students from undue sacrifice of exercise or sleep, but of direct teaching as to how to obtain and maintain the physical health which is essential to success, almost nothing. Recall, now, for a moment, what has been accomplished for our race simply by teaching and practicing some simple rules of health. The average of human life has been doubled in four hundred years; by the progress of the past thirty years, six years have been added to your life and mine, and by the practical application of facts well known to sanitarians, eight or ten years more are within our grasp.

Of all the children in our various communities, nearly 99 per cent. are in our schools. Here, obviously, is the opportunity for reaching not only the coming generation, but almost every home in this generation. We have made a fair beginning in the matter of the control of contagious disease, through the excellent work of our medical inspectors. We have come to a practical recognition of the fact that nearly all the transmissible diseases,—measles, scarlatina, diphtheria and the rest—reach their high water mark about the middle of the school year, after our children have been congregated in class rooms for some weeks, and that, conversely, they reach their lowest ebb toward the close of the summer vacation, after the children have been scattered and kept in the open air.

The work of our inspectors is not now limited to the exclusion of children who are suffering from transmissible conditions; it includes the notification of guardians in cases of individual defects which are remediable, such, for example, as adenoids, diseased tonsils, defects of hearing, vision, etc. In this way we are trying to take a step in the direction of preventive medicine, and practical sanitation. You are aware, of course, that in the case of our mental defectives we are applying the intelligence tests that were first systematized by Binet and Simon, of France, and are teaching them in separate classes, by specially trained instructors. Now all of this is for the diseased, or defective, or abnormal child; for the normal

child, we are doing comparatively nothing, as if totally failing to recognize the fact that the basis of a long and an efficient life is hygienic living. We are giving our children a hygienic environment,—witness the various provisions of our modern school buildings; but we do not yet sufficiently recognize the fact that the education of the normal child represents the main educational problem, nor that the hygienic training of the normal child should be the main element in hygienic education.

The medical value, to the community as to the individual, of instruction in hygiene is twofold; it is corrective and preventive. And hygiene for the normal child will, of course, reach the great bulk of our school population, since about 92 per cent. of our children must be regarded as normal, in spite of numerous slight physical defects; the normal child is not a perfect child, physically or otherwise.

Only the barest outline of instruction in hygiene is here possible. It should include directions as to avoidance not only of tuberculosis, but of all other infectious diseases, and this should include a discussion of the germ theory of disease. The value of proper environment, of fresh air, open windows, free ventilation, should be emphasized, as affecting general conditions; and we can afford to dwell upon the statement that, as between heredity and environment, the latter is the more important. Permit me to enumerate some of the subjects which should receive attention in a course on hygiene:

Cardiac troubles demand discussion of problems that deal with the circulation generally, as adequate exercises, proper methods of breathing, the advantage of physical education, and the danger of overstrain and, especially, of overindulgence in athletics.

Pulmonary diseases require attention to correct breathing, the disposal of sputum, especially its protection from insects, the importance of fresh air, the dangers of dust, and of infections by direct contact.

Hygiene of the skin demands instruction as to the value of bathing, the various kinds of baths and their effects, the use and abuse of soaps, and the necessity of the individual towel. Contagious skin diseases should be carefully discussed, together with the importance of protecting the various lesions and destroying soiled dressings.

Care of the eye includes suggestions as to the proper position for reading, writing or studying, the amount, character and

direction of light, the relation of vision to occupation, the dangers, with methods of avoidance, of contagious diseases of the eye, and the importance of the use of proper corrective lenses at a proper age.

The preventive phases of hygiene are evident in such problems as vaccination before entering school, the exclusion of contagious disease, quarantine and isolation under the health department, and the purpose and value of medical inspection in school and home. The use of the individual pencil, and of the modern drinking fountain instead of the common cup, all these have their lessons in prophylaxis. Care of domestic animals, and their possible serious menace as carriers of infection should not be overlooked.

We may develop an interesting chapter on hygiene of the home, as relating to kitchen, dining-room, living-room and sleeping-room, and involving problems of air, light, sleep, clothing, heating and bathing. In this connection at least an outline of the essentials of dietetics should be taught. Industrial hygiene is another important branch, with its problems of dust, chemical exhalations, danger of accident and the rest, and the broad question of the proper adjustment of a man to his occupation.

There are educational phases of instruction in hygiene that we must not overlook, culture, economic and social. We must remember that civics and health are closely allied; that geography presents many applications of the principles of hygiene to the question of housing, clothing and feeding under various climatic conditions. We may cite some striking examples of the far-reaching effects of practical hygiene to illustrate our teachings. We Americans are rather proud of the fact that our great engineer, Colonel Goethals, has built the Panama Canal—we are apt to forget that our great sanitarian, Colonel Gorgas, made it possible for him to do it. Goethals conquered the Chagres River, after Gorgas had conquered the Chagres fever, and to my mind the latter was the greater accomplishment. Under DeLesseps the canal zone was a pest-hole; under Goethals and Gorgas its morbidity and mortality rates compare favorably with those of the average American city.

We should impress the fact that individual health means community health, and that, by a step further, means national health. We should add that the greatest possible national asset is not bank balances, but national health; and in this connec-



tion, by a very reasonable deduction from past accomplishments, we may claim that, if teaching such as I have hastily sketched were universal in our schools, the life of the average American would be increased five years within the next generation.

Our school curricula are now so crowded that it might be best, for this and other reasons, to give this instruction in the form of illustrated lectures, so arranged, in duration and frequency, as to be restful rather than burdensome. I would suggest that the first lecture be given on the first day of kindergarten, and the last one on the last day of high school; there will be quite enough if properly graded to fill in the intervening years. And in view of the fact that our school children of to-day will be the home-builders of the next generation, I believe that if such special lecturers on hygiene were added to our teaching force now, no matter at what cost, it would be the best investment ever made, both by the community at large and by the individual taxpayers.

#### DISCUSSION OF DR. ADAMS' PAPER.

Dr. Adams in covering the question of hygiene as a part of our public school curriculum, has left his discussor but little to say other than, Amen! The value of such instruction cannot be overestimated and it is a welcome sign that so many prominent psychologists and sociologists throughout the world are turning to a consideration of eugenics and the tendency is becoming more and more general to appreciate the tremendous opportunity which presents itself in our public school, to begin at last the study and work which must mean so much to the generations to come.

The old saw that "a child's education should begin with its grandparents," is one of the truest quotations in the English language, and probably no profession is brought so face to face with this homely truth as is ours. The normal child presupposes a normal and clean heredity, and this statement leads to another equally important truth that the child is entitled to a clean and sound heredity, since his very existence is an accident so far as he himself could govern it, and he should at least have a sound bodily and mental foundation upon which to build and grow. It is too late after the child begins to exist, to lament the fact of tainted heredity or to try to alter the condition, but it should be the greatest incentive to begin with this child the education and knowledge which will guar-

antee a perfect and bodily sound grandchild. It is a fact that the vast majority of our defective, or even partially abnormal children are the result of a hereditary taint directly traceable to diseases contracted through exercise of the sexual function, the most wonderful and precious function of the human body, and sad to relate the function which is talked about with bated breath in the presence of this child we are trying to educate, and to which not one moment of school time is devoted except in a very general way, and the hygiene of which is not touched upon from kindergarten to high school graduation. It is a blot on the present day civilization, of which we seem so proud, that posterity must be forever cursed because of the false prudery with which this greatest of God-given functions is approached. Knowledge of the gift of reproduction should occupy as prominent a part in our child's education as should a knowledge of the three "Rs," and there is no reason in the world why this cannot be imparted in such a way that the sensibilities of the most fastidious should not be offended. Ignorance of the sexual function is the most dangerous obstruction in the path of the growing child to-day, and is the cause of more misery, illness and suffering than any other combination of hazards that beset the path of life from the cradle to the grave.

Let us then use our influence actively that the public school may be not only the fountain of literary, commercial and historical knowledge, but also the well from which shall be drawn full knowledge and understanding of all the functions which form the complex of that most beautiful and wonderful of all creations—the human body.

DR. WESTNEY.—In driving through this beautiful city of Montclair this morning, coming to this meeting, I passed one of the open air schools, a lot of children sitting in the open air. I have some children of my own in school, not in this Montclair open air school, but in the city where I live. Occasionally I take the opportunity of visiting the school. And although they had expensive apparatus and magnificent ventilating systems, some fifteen or twenty children were kept after school, which I think is a bad plan, while the janitor swept the rooms and the dust was flying. At another time I visited the school and the children were sitting with the direct rays of the sun coming through the windows and striking them full in the face for two hours in the afternoon. The point I want is that some excellent equipment is rendered practically of no use, and until such time as we have these sanitary dangers established as part of the school curriculum, it strikes me it would be a pretty

good idea that we physicians, and particularly those who have children in school, step in and use our professional influence toward correcting the things that should be corrected. I know that proper suggestions to the school board have some decided effect.

DR. PERKINS.—I had the fortune last year to be school inspector, with about eight hundred and fifty children in charge, in a very fine school building costing about one hundred thousand dollars. The first time I visited it I found no curtains in the windows. I reported immediately to the principal, who referred the matter to the school directors. I thought the matter would certainly be attended to, but it went on for about two months, but there were still no shades. I determined to get busy, and I interviewed pretty nearly all the members of the board on this matter of shades. Well, it was in the hands of a committee. This committee business, you know, it does more to keep things from being done than anything I know of. The trouble with it was that they didn't wish the contract for shades to go out of town, they wanted some business man in town to get it. Then I had all the school children examined, and prepared statistics, and found that eighty children had become defective in their vision since my fall examination simply because they had not proper shades in the rooms. I got a list of these pupils and I put those names in the hands of several organizations in town, and it was not long before I got shades after that. That is a very important point,—the light in the room.

DR. VOORHEES.—I would like to speak on sex hygiene. I believe it should be taught in the public schools. It is a most important subject, bringing up, as it does, all the relationships of life. I think it is up to the physicians, we who come in contact with the mother, from the time the baby is born, to instruct the mother how to tell the children. If we don't do it it is our fault.

DR. C. H. CHURCH.—One thing came to my attention yesterday morning, I don't know whether it was in the discussion or in a paper,—the idea that the training of a child should begin with its grandfather. A patient came to my office and gave me this history. While her mother was pregnant before she was born, she tried everything she could to get rid of her. This patient says, "I have always had to fight the temptation to get rid of myself. If any little thing goes wrong my first impulse is to get rid of myself." That is one incident that we may bring to the mothers who try that sort of game.



DR. ADAMS.—In reply to Dr. Willard's discussion of my paper, if I say that during the past three months I have made four public addresses on the subject of sex education; the first before the Union League Club of Bergen County, the second before the united Masonic lodges of Bergen County—all of these by invitation, of course—the third before the Young Men's Club in our town, the graduates of our High School, and the fourth before the Home and School Association of River Edge, it will be appreciated that I have not overlooked this very important question. We in Hackensack, in our modern school buildings are doing everything we can to surround the children with hygienic conditions. There will be included in the new grammar school, which we are just finishing, forced ventilation, and heat, light, proper room space, and everything of that sort. Those of you who are not on local boards of education, I want to ask you "how much are you doing for your community?" How much of it is strictly professional? How far are you trying to exercise your professional ability for helpfulness in your community? There is much that you can do. Four of our school buildings had white glaring walls, which the children faced all day long. They are now tinted. I think I have prevented a few hundred cases of neurasthenia—things of that sort—ripped out the old toilet rooms, put in new modern installations, insisted upon proper ventilation. The next thing I did was to get the State Inspector to go through the entire system, and his report was something that nearly killed the other eight members of the board from heart disease. You ought to be conversant with the State regulations on those things. You ought to take a personal interest, feel a personal responsibility for the care of the children of your families, not only when you are called to take care of them in sickness, but follow them in school. If I may put it on the ground of expediency, it would be the very best investment you can make.

**THE SCOPE OF MANUAL THERAPEUTICS.**

BY

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IN presenting this paper before you to-day I can only hope to give you a general summary of manual therapeutics. It is a subject which is each year commanding the increased attention and interest of progressive physicians, and it appears not inopportune to consider in general its scope at this time. And in order that this society may not appear to be establishing a precedent, it may be of interest that on previous occasions contributions on this subject have been made before the National Society of Physical Therapeutics, the National Society of Orificial Surgeons, the American Association of Clinical Research, and several other medical societies.

Within the scope of this paper I shall not attempt to review the various methods and practices in which the hands are used as therapeutic agents. Rather, I shall confine myself to the consideration of the school of practice known as osteopathy, taking up (1) the original concept of Dr. A. T. Still and the etiology upon which this practice is founded, and (2) to correlate these principles to the treatment of disease.

Quoting from the "Autobiography" of Dr. Still he gives the following key to fundamental principles:

"In the year 1874 I proclaimed that a disturbed artery marked the beginning to an hour and a minute when disease began to sow its seeds of destruction in the human body. That in no case could it be done without a broken or suspended current of arterial blood, which by nature was intended to supply and nourish all nerves, ligaments, muscles, skin, bones, and the artery itself. The rule of the artery must be absolute, universal and unobstructed, or disease will be the result."

To elaborate further, a technical definition must suggest a theory of the cause and the treatment of disease. In regard to the latter it must embrace not only therapeutics but prophylaxis as well. The theory of medicine is that from a physiological standpoint it is possible to employ scientific means to preserve and prolong life, and when life is threatened by disease or accident, then certain physiological principles may be brought into operation in connection with the body system to alleviate or cure these conditions that threaten to destroy

life or to interfere with and lessen health. In all ages attempts have been made to apply measures to the human system with this end in view. Medicine, therefore, in the broad sense of the term must include, in addition to measures employed to assist the body in recovering its equilibrium those measures designed to assist the organism in maintaining that equilibrium. In order that a definition shall include these essentials, the following premises are advanced: (1) Functional disorders will be self-adjusted except when they are complicated with or dependent on structural disorders which are beyond the limits of self-adjustment; (2) removal of structural disorders constitutes the treatment.

In accordance with these provisions, a definition has been proposed by Dr. J. M. Littlejohn as follows: "That system or science of healing that uses the natural resources of the body as curative agents. To this end means are used for the adjustment of structural conditions and relations that may have become abnormal, in order to insure the proper preparation and distribution of the fluids and forces of the body, and to secure the co-operation of functional activities, so as to promote harmony within the body mechanism."

Another definition and perhaps the most practical explanation of etiology is: "A system of treating disease without drugs and by the use of the hands to adjust all parts of the human mechanism to perfect mechanical relations. It is that science which finds in disturbed mechanical relations the causes of disease, and which is employed to cure disease by applying technical knowledge and manual skill to the correction of all disturbed relations occurring in the mechanical arrangement of the body. The word does not mean the treatment of bones, nor of bone diseases. It was used as a name because the founder discovered the importance of disturbances in the bony framework of the body in causing disease. He studied the skeleton as the foundation of anatomy, upon which science he grounded his system. The meaning of the word applies not only to derangements of the bony parts, but as well to disturbed relations of ligaments, tendons, blood-vessels, muscles, nerves, and of any body tissue."

These definitions, as well as others which have been proposed, lay stress upon diagnosis in the sense of determining the first cause, and the relation between it and the secondary causes which often determine the most noticeable symptoms.



Much has been said about the usage of the term "lesion" or subluxation. As it is probably the one basic factor in etiology which is most at variance with other principles in the treatment of perverted function and resulting disease, a consideration of the lesion is logically in order.

Broadly speaking a lesion is "any morbid alteration in a tissue whether attended by a recognizable structural change or not; but especially a change in which the continuity of some of the tissue elements is broken in upon." The surgical application is "any injury to a part," and the pathological concept is "any local or circumscribed area of tissue undergoing abnormal functional changes." Hulett defines the lesion as "any structural perversion which by pressure produces or maintains functional disorder."

In elaborating upon this latter application of the term as applied to the osseous lesion, the pressure upon the tissues contiguous to the joint is due to the changes not only in the position of the joint itself, but also in the tissues composing it. Granted, in many cases structural perversion due to slight trauma may become self-corrected, in the same way that any sprain may be a self-reduced dislocation. In lesions due to simple muscular contracture from thermal or other changes, the condition may not continue after the original stimulus is removed. If, however, the contracture continues, or the articulation is limited in its motion, due to a fall, a blow, or a strain, there will also be shortening of the ligaments, exostosis, or inflammatory deposits around the joint, the entire connective tissue elements entering into the joint being involved.

In this connection it will be of interest briefly to review what occurs when a joint is sprained. The condition is defined by Tillmans as follows: "A sprain is a severe wrenching of a joint followed by stretching or tearing of one or more of its ligaments with effusion of serum or blood into the joint cavity, the extra-articular tissues, or both. They are caused as a rule by the same sort of violence, though in lesser degree, as that which produces dislocations; that is, by forced movements carried beyond their physiological limits, or by movements at variance with the normal mechanism of the joint. In severe cases, the ligaments, being inelastic, give way and are partially or completely divided or are detached from their insertions; the tendinous sheaths and contiguous muscles are often torn, sometimes at a considerable distance from the articula-

tion, and tendons are frequently displaced or severed from their insertions. The blood-vessels in and around the joint may be ruptured, causing the joint cavity or the surrounding tissues to be filled with blood. The line of displacement in sprains usually takes the direction in which there is normally least motion."

Correlating this condition in its application to the vertebral segments, each of the articulations of the spinal column is not only subject to the torsions and wrenches producing the condition of sprain, but the column as a whole in the erect posture is constantly subject to the strain induced by gravity and the weight of viscera. That these localized spinal sprains have been so frequently overlooked or ignored is due not only to the small size of the articulations, but also because so little consideration has been given to them as a factor in perverted function and tissue change.

Having outlined the concept of this newer school as applied to perversions of the musculo-skeletal framework, I shall omit for the sake of brevity a review of the origin and distribution of the spinal nerves, the connection with the sympathetic nervous system, together with their physiology, all of which is too well known to need repetition at this time. The newer etiology of this practice is in relating the lesion with the normal functioning of these nerves and with the impeding of blood and lymph flow in contiguous spinal and sympathetic ganglionic centres.

The precept originally advanced by Dr. Still, who may be said to have discovered the therapeutic possibilities of the spine and contiguous tissues and articulations, has not altered materially since it was first proposed. His original premise was that interference with the normal distribution of the artery, or direct or reflex disturbance to nerve pathways, would result in perverted function or disease, and that as a result of sub-luxations or lesions, the efferent impulses from the cerebro-spinal axis and afferent impulses from the viscera would not be conveyed normally. The corollary to this is to determine, by means of the application of this newer etiology, what structural or tissue perversion exists, and to remove it by corrective mechanical technique.

The question naturally arises, What evidence has been deduced in proof of this newer etiology of disease? Clinical experience has proven in many thousands of cases the existence

of lesions of various degrees and types, and the relation and effect of these lesions on the various tissues and organs of the body. Autopsy findings have given further evidence of lesions affecting the vertebræ and ribs, with resulting disturbance to related nerve pathways and to blood and lymph vessels, and finally, evidence of disease of related organs. In recent years animal experimentation has been giving added evidence of the potency of the lesion. Not only have physiological changes been induced in various viscera by mechanical inhibition and stimulation to spinal centres, but pathological changes have been observed in viscera as the result of artificially produced vertebral and rib lesions.

Of clinical interest is the application of these precepts to therapeutics. The science of anatomy, physiology, and pathology appear to be so well established that the question naturally arises, What has this newer school developed which was not known or utilized before? The musculo-skeletal framework has been given such comparatively little consideration as a factor of perversion of function and tissue change that it remained for Dr. Still and his followers to develop a distinctive etiology in the diagnosis and treatment of disease. Clinical experience, plus animal experimentation, each year is giving further evidence in support of these precepts. For years the art of manual therapeutics was far in advance of its scientific development. The Research Institute, endowed by the followers of this school, the laboratories in connection with various colleges, and the practitioners, are placing this system on a basis of scientific achievement.

In answer to the question, What is the theory of manual therapy and what is the treatment, as applied to certain diseases? the reply is, the therapeutic scope of this practice can be determined, in the individual case, only by correlating the symptoms and the physical findings, and then applying corrective manual therapy in accordance with the principles set forth in this paper.

Bibliography.—Reference Handbook of the Medical Sciences, McConnell and Teall's "Practice of Osteopathy," Hulett's "Principles of Osteopathy," Clark's "Applied Anatomy," Willard in "Journal of Osteopathy," Booth's "History of Osteopathy," Littlejohn in "Journal of the Science of Osteopathy," "Journal of the American Osteopathic Association."



## DISCUSSION OF DR. MATTISON'S PAPER.

PRESIDENT FRANK P. EKINGS.—I have one remark to make. Dr. Mattison is a graduate of the Osteopathic Institute, as well as our New York Homœopathic Institution. He is a D. O. as well as an M. D. I find that the printer failed to give him either one of these degrees on the program.

DR. ADAMS.—I am very glad to add my personal thanks to the thanks of the Society. You will understand without my going any further into the matter my faith in osteopathy in certain cases from my own personal experience, of which I spoke this morning. Since that experience I have referred the head of my house to an osteopath, with results that have been very satisfactory to her. I regard osteopathy in fact as one of my regular resources, and I try to differentiate my cases, and refer some of them just as regularly to the osteopath as I do others to the surgeon.

DR. SLEGHT.—I have had no personal experience with osteopathy, but my wife was intimate with a lady who a short time ago, after many years of sterility, gave birth to a child, and she ascribed the fact to a certain osteopath whom she had visited. It seemed a strange fact to me, but I leave it with you to discuss it, if you care to.

DR. CHURCH.—The speaker has brought out a fact which I think we should think of. I have heard a great deal about osteopathy, and I find, judging by the paper, that I did know a little bit about it. I have heard so much cursing at osteopathy. When you get at the real fact of the matter, it is nothing more than, if you paid a little more attention to manual therapeutics, any one of us might apply, and that we believe in. We all believe in changing any maladjustment. It seems to be true of the medical profession—perhaps not any more true of the medical profession than of any other profession—that if we do not understand a thing, we curse it. I simply want to say, don't scold it until you know what it is.

DR. MATTISON.—I am not speaking of my own individual opinion, but reflecting the opinion of the school, when I say that it is inclusive.

Just a word in regard to sterility. Sterility may be influenced by other conditions which may be discovered by the

osteopath. There are a great many hundreds of cases on clinical record, of the reports of osteopathic practitioners, of cases of sterility which have been corrected by the correction of abnormal conditions in the lower lumbar region. I do know that the matter of sterility has been corrected by osteopathic methods. As to the general practitioner, the matter of the general lack of attention of the general practitioner to these subjects was spoken of. Variations from the normal should be examined for by the general practitioner, and if they are found, the osteopaths should be consulted regarding them.

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### TREATMENT OF DISTURBANCES IN POSTFETAL DEVELOPMENT.

BY

FLORENCE E. VOORHEES, M. D., NEWARK, N. J.

PRESIDENT and members of the New Jersey Homœopathic Medical Society, this paper is written to arouse your interest in minor, not major, disturbances in postfetal development.

Statistics prove to us that 25 to 30 per cent. of children are scoliotic. Of 172 children examined in the public schools of Newark 56 had one or more of the following disturbances—flat, pigeon or funnel chest; protruding abdomen; round shoulders; prominent scapulæ; lumbar kyphosis; lateral scoliosis; the usual combination being flat chest; protruding abdomen; round shoulders; lumbar kyphosis.

This is an era of preventive treatment and these disturbances of development, if treatment is instituted at an early date, can be corrected. These conditions lead to permanent deformities of the spine and thorax, diminishing the size of the thoracic cavity and thereby crippling the development of the lungs, and by the partial use of the apices and lower lobes of the lungs, providing a good field for the lodgment of tubercle bacilli.

My personal belief is that a very small per cent. of the human race know how to breathe, especially women, because of the corset restricting the motion of the lower ribs, which should play such an important part in abdominal breathing.

In the treatment let us first consider the causative factors. The bony skeleton which was originally planned to assume the position of a quadruped, had to overcome many obstacles be-

fore it changed and adapted itself to the new surroundings. The vertebral column and lower extremities are especially affected by weight. Therefore our first step in preventive treatment is to guard against deformities when the change from the horizontal to the erect position is taking place.

Pathological disturbances, especially rachitis, augment the danger of deformity in development at this period.

The child's first step should be spontaneously taken and never urged or encouraged. If parents could be made to realize the importance of creeping—creeping meets the natural requirements and trains the bones and muscles to bear weight later on. When children are taught to stand on their feet too early, the untrained muscles, bones and ligaments yield to overweight and deformities of the foot are produced, the marked degree of which is termed flat-foot. Have a naked child creep for you and see what a marked influence it has upon the vertebræ and muscles of the spinal column. At the present time a child five years old who had a marked lordosis from the third to the twelfth dorsal vertebræ and kyphosis of the lumbar vertebræ, has entirely corrected that deformity by creeping ten minutes morning and evening; also twenty minutes a day of abdominal breathing, which will be described later on.

Do not permit the child abnormal locomotion, such as sliding over the floor on the buttocks which enforces a sitting posture at too early a date.

The child must change spontaneously from the creeping to the walking period.

Let us next consider Prof. Lange's description of the changes which normally take place in the spinal column during the first two years of life. The vertebral column of the fœtus generally forms one single curvature, the convexity of which is directed backward. At the third or fourth month the child begins to lift the head and turn it backward. Thus the cervical region now changes from the original kyphotic condition to a lordosis with the convexity forward.

A second change takes place at the end of the first year when the child begins to walk. The muscles of the back, which hitherto have been of little use, are now set in motion. They arise from the sacrum and are inserted at the lower dorsal region of the spine. In contracting they force the kyphotic curvature, which, until then was formed by the lumbar region of the spine, gradually forward and finally transform it into a marked lordosis.



Now the change from the original kyphotic curvature is, an anterior lordotic curvature in the upper cervical dorsal region, the original kyphosis in the dorsal region and the anterior lordotic projection in the lumbar region. Thus the long S shape is attained which the spine presents in adults of erect and faultless carriage. A continuous and harmonious co-operation of numerous muscles is essential to retain the spine in a normal position. The posterior muscles located on both sides of the spine, tend to increase the lordosis, while the anteriorly located abdominal muscles tend to augment the kyphosis.

The normal posture is not only dependent on the spine, but it is subject also to the position of the pelvis. The connection of the spine with the pelvis is rather rigid, therefore the attitude of the spine is intimately related to the pelvis. The pelvic motions are based on an axis connecting both hips. In the erect attitude with the legs fixed, when the flexor muscles become active, the anterior part of the pelvis is tilted downward and the plane through the superior pelvic entrance becomes nearly vertical. This pelvic position is called increased inclination of the pelvis. The reverse takes place when the extensor muscles of the hip are brought into action. The posterior part of the pelvis is then tilted backward and the superior pelvic strait appears more or less horizontal. This attitude is termed decreased inclination of the pelvis.

To get prompt information of the normal appearance of the spine and pelvis in a living person, Schultzhess suggests that a vertical line be drawn from the cervical region down to the lowest point of the sacrum. Such a line in a normal case must either slightly touch the dorsal curvature or pass very near it.

Now that we have studied our normal condition, we will understand the line of treatment pursued in abnormal conditions.

#### THE TREATMENT OF LUMBAR KYPHOSIS.

1st. Associated usually with flat-chest, faulty attitude of shoulders and protruding abdomen.

The causative factors in producing this deformity are pathological conditions, such as rachitis.

2nd. The erect position at too early a date causing an overaction of the extensors of the thigh, which produces a decreased inclination of the pelvis and pronounced kyphosis.

3rd. Faulty positions assumed, due to carelessness in the

school room, which may be due to the inability of the child to rest the feet on the floor or to a low desk which naturally produces lumbar kyphosis, round shoulders and flat chest.

Also the habit of standing incorrectly with the abdominal rectus relaxed.

#### TREATMENT.

Remove the cause, if possible. The rachitic pathological condition should receive appropriate treatment, also the correction of faulty habits.

The following exercises, if persisted in one or two hours daily for three months, will entirely correct the existing deformity.

The energetic erect position must be understood before dealing with the different exercises. Have the child place the heels together and the toes about one inch apart, let him extend the knee forcibly, abdominal rectus taut, chest high, the shoulders backward and held half way between the positions of high and low; chin held at a right angle with neck. A vertical line passing downward should strike the ear, hip, and Chopart's joint

#### DEEP BREATHING.

1st step. Erect energetic position.

2nd step. Relax the abdominal rectus muscle, lower the chest, spread the shoulder-blades apart.

3rd step. Inhale as though smelling of a flower, permitting the abdomen to protrude, lower ribs spread outward and upward. The sub-clavicular spaces filled out and the dorsal vertebræ pushed backward, pushing the scapulæ apart.

4th step. Full inspiration having been attained, the breath is held, the abdominal rectus is contracted, the chest raised, the shoulder blades are pushed backward.

5th step. Exhale by keeping the abdominal rectus contracted and forcing the air out by the downward inward motion of the lower ribs, not permitting the chest to flatten.

This method of deep breathing has corrected many cases of flat chest, round shoulders and protruding abdomen without resorting to other exercises. It must be persisted in correctly for twenty minutes morning and evening with windows open. I wish to lay great stress on this abdominal breathing, for it will increase the lung expansion from  $1\frac{1}{2}$  to 3 inches. We will

say that the child has an expansion of  $1\frac{1}{2}$  inches; that expansion can readily be increased to 3 or  $3\frac{1}{2}$  inches with a marked improvement in general nutrition of the child.

The following exercises aid materially deep breathing by developing the size of the thoracic cavity and building up the muscles of the chest and back.

#### FIRST EXERCISE—FORWARD BENDING.

- 1st. Erect position.
- 2nd. Deep inhalation.
- 3rd. Arms extended and hands raised slowly above head, palms forward.
- 4th. Slowly bend forward keeping the arms parallel and the head between the arms, touch the floor with the fingers ten inches in front of the toes.
- 5th. Reverse steps on returning; exhale by method previously described.

#### SECOND EXERCISE—BACK BENDING.

- 1st. Erect position.
- 2nd. Deep inhalation.
- 3rd. Arms extended, slowly raise hands above head, palms forward.
- 4th. Forcible extension of the lumbar vertebræ. Knees straight. Repeat extension of back three times.
- 5th. Returning, reverse steps, exhale.

This exercise produced a marked lordotic curve of the lumbar vertebræ and development of the erector spinæ and multifidus spinæ muscles.

#### THIRD EXERCISE—TRUNK TWISTING.

- 1st. Erect position.
  - 2nd. Deep inhalation.
  - 3rd. Arms extended, slowly raise hands above head, finger tips touching.
  - 4th. The body is rotated at the waist, the knees facing forward and straight.
  - 5th. Flex the body to a right angle at the waist line, bringing the extended arms horizontal with the shoulders.
- Returning, reverse step, exhale.



FOURTH EXERCISE—SIDE BENDING.

- 1st. Erect position.
- 2nd. Inhalation.
- 3rd. Arms extended and raised horizontally with the shoulders.
- 4th. Bend toward the side extending the hand of the side toward which you are bending—flex other hand. Touch the floor to one side and just in front of the foot.

Reverse steps, returning to erect position and exhale.

FIFTH EXERCISE—ARM AND UPPER TRUNK EXERCISE.

- 1st. Erect position.
- 2nd. Deep inhalation.
- 3rd. Energetically flex fingers then the arms, raising elbows outward and upward and extending arms above head.
- 4th. Flex arm, bringing the thumbs to shoulder. Extended arm.

- 5th. Reverse steps in returning to erect position and exhale.

To insure a correct inclination of the pelvis the erect position plays a prominent part, also the walking exercise which consists of the following steps:

WALKING EXERCISE.

- 1st. Erect position. Hands clasped and palmer surface cradling occiput.

- 2nd. Right lower extremity lifted one inch from floor; right limb raised forward, knee straight, toes extended.

- 3rd. Flex knee, toes extended.

- 4th. Place the ball of foot on floor, gradually throwing the weight of body onto right limb and bring heel to floor; simultaneously rise on toes of left foot and keep the knee straight.

- 5th. Raise the left foot and bring forward to vertical position, keeping the knees straight. Foot one inch from floor.

These steps repeated constitute the walking exercise. I have taught these exercises to the parent and had the exercises of the child supervised by the parent, having the child and parent report three times the first week to insure a correct carrying out of exercises, then report at two week intervals. The results are excellent; the child not only corrects the minor deformities but improves markedly in general nutrition.

Creeping is added to the given exercises as it has a decided value in increasing the mobility of the spine and developing the muscles of the back and shoulders.

TREATMENT OF PIGEON BREAST, SYNONYMOUS KEEL-SHAPED CHEST—PECTUS CARINATUM.

When there is a slight deformity, the previous exercise will entirely correct.

When marked deformity the following method is resorted to: the deep breathing exercise during which backward pressure is made on the sternum and pressure forward on the ribs either side of the middle dorsal vertebræ.

TREATMENT OF THE FUNNEL CHEST OR KYPHOSIS OF THE STERNUM.

The deep breathing and exercises that develop the pectoralis major muscles produce excellent results.

TREATMENT OF LATERAL SCOLIOSIS.

In the first stages it is markedly benefitted by the foregoing exercise. If the case is fully developed, not only equilateral action of the muscles of the back, but exercises must be added which aim at bending the scoliotic part of the spine and this part alone, so as to stretch the shortened tissues on the concave side and strengthen the over-extended erector spinæ muscle of the convex side.

In a convex scoliosis to the right I found the following exercise beneficial:

- 1st. Erect position.
- 2nd. Deep inhalation.
- 3rd. Left hand is placed on head and right hand below the costal hump.
- 4th. The left elbow is raised, the hand remaining on head and the right hand exerts strong pressure against the costal hump.

In closing this paper I would like to state that my interest in the correcting of minor deformities was deeply aroused in Berlin four years ago.

A physical culture institute, conducted by Dr. Bess M. Men-

sendieck, a graduate of the Leipzig University, was conducted as a sanitarium, patients being admitted for a three months' treatment. The patient exercised one hour with Dr. Mensendieck, and one hour or more alone each day. The body was nude during the exercise and it was upon this fact that Dr. Mensendieck based her success. It was my privilege to see a class of eight on entrance and their condition at the end of a two months' period was markedly improved.

When we consider the majority of these patients were over twenty years of age, and the good results obtained by systematic exercise, a natural deduction would be that children between the ages of four and twelve years of age, suffering from minor disturbances in postfetal development, would readily respond to treatment and my experience has proved this to be the fact.

#### ENERGETIC ERECT POSITION.

The energetic erect position must be understood before dealing with the different exercises. Have the child place the heels together and the toes about one inch apart, let him extend the knee forcibly, abdominal rectus taut, chest high, the shoulders backward and held half way between the positions of high and low; chin held at a right angle with neck. A vertical line passing downward should strike the ear, hip and Chopart's joint.

Discussion of Dr. Voorhees paper was opened by Dr. Bingham.

DR. BINGHAM.—I want to congratulate Dr. Voorhees on the results she has obtained, particularly in this case, and on the care she has used in selecting the exercises in the case she has just shown. I agree with her that in treating a case of scoliosis one of the best things is a change in the surroundings and occupation of the patient. The child must be daily exercised in walking and sitting and standing under the direction of a competent teacher or attendant until he begins to assume the correct attitude naturally. It seems to me we are in the habit of prescribing exercise in gymnastics, depending on the variety of the curvature, without taking into account the growth and age of the child. We believe from experience that light dumb-bells form one of the best methods of general exercise. While this does not develop the muscles of the back,



it does encourage a systematic cultivation of all the muscles of the body. The other exercises for developing the special muscles of the back, as I say, must depend on the variety of curvature, age and sex of the child. We must bear in mind that a method that will do for a muscular boy will not do for a delicate girl.

Dr. Voorhees has spoken of scoliosis. I wish to speak of another method of treating this deformity. It is based on the theory of over-correction, and is used by one of our orthopedic surgeons. To test it he secured the services of a student to give himself up to experimental work. A plaster cast was applied, and a dorsal scoliosis was produced by the wearing of the cast or jacket for a period of three months. When it was removed it was found that the young man had developed a structural scoliosis. This was then over-corrected; another jacket applied, and kept on for a period of three months. When it was removed it was found that the vertical column was practically straight. This applies to structural scoliosis, not to the milder types, which I believe are absolutely curable by gymnastics and training in the proper method of standing, walking and sitting.

DR. C. H. CHURCH.—One point in this method of exercise is, I think, important, and that is the tension,—every muscle on tension, as we saw in the case of this young girl. As I understand it, that is one of the great objects. If you will give them something to grip,—not wood, with no spring to it, but possibly cork, a wad of paper or a ball, anything that has a little “give” to it, you will find you get a great deal more tension.

DR. EKINGS.—I think it is not a question of gripping of something, so much as one set of muscles operating against another, as abductors against flexors.

DR. ADAMS.—I am interested in this paper, of course. I am enthusiastic on the matter of physical education, and have been since I was fifteen years old. I am myself more or less an example of the results of physical education, for when I was a young man I found myself in a condition where the doctors and wise men came together and shook their heads and made more or less scientific guesses on how long I was to live. I went to Long Island and put myself under the care of a physi-

ical trainer and followed a system of training for about eighteen months, laying a foundation for the present condition of my biceps and triceps. (Indicating.)

DR. YOUNGMAN.—I think an additional benefit from this exercise is the effect upon the heart. If you studied that young girl's heart after she finished that exercise, you would have been surprised at the strength and vigor developed in both her pulmonary circulation and to the left side of the heart. I think, with the general nutrition and the increased appetite, the most important effect is the effect upon the heart. It is the effect upon the heart that is the most valuable part of the treatment, aside from the correction of a deformity.

DR. VOORHEES.—In reference to Dr. Church's suggestion of a spring in the hand in these exercises, the greatest number of them was with full flexion of the muscles; if you have a weight in your hand, or grasp a spring, you would not get that. Of course, I have tested these exercises by the results accomplished in the correction of deformities. This paper was written with the idea of speaking of the minor deformities, as slight curvature, bad position of the shoulders, protruding abdomen, not so much lateral scoliosis. About the heart action, I thoroughly agree with Dr. Youngman. I have seen a marked improvement in the heart and in the general circulation from the persistent systematic use of these exercises.

DR. CORNELL.—I want to thank Dr. Voorhees first, and then to make a motion that we adjourn and have Dr. Bingham's paper this afternoon.

DR. CHURCH.—As chairman of the Committee on the President's Address, I wish to report, and make a motion that the report be adopted and the address spread on the minutes. (The motion is seconded and carried.)

DR. CHURCH.—I move that the incoming president be instructed to appoint a committee of three, on propaganda. (The motion was seconded and carried.)

## EDITORIAL

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### CONDITIONS OF HEALTH AMONG THE AMERICAN INDIANS.

DURING the last few months the Government report on the health and sanitary conditions of the North American Indians has been placed before the public. As was to be expected, sanitary conditions on the reservations are very poor and the personal habits and customs of the Indians are far from satisfactory. Laziness seems to be an almost universal state among the American aborigines at the present time and, with but few exceptions, there seems to be very little tendency to put forth the effort necessary to insure regular food supply and clean surroundings.

Tuberculosis was found to be the most destructive disease prevalent among the Indians. The proportion of those suffering from tuberculosis is much higher than among the white race. Ninety-five per cent. of the children among the Apaches in New Mexico gave a positive Von Pirquet reaction: about one-third of the Plutes, of Nevada were found to be tuberculous. Conditions are, of course, extremely favorable for the further spread of this disease and the Department of Public Health states that the situation as regards tuberculosis is so serious that immediate and vigorous measures are required to stem the progress of this malady.

Trachoma is also commonly met with.

Of a total of 39,231 Indians examined, 8,940, or a little over 22 per cent., were suffering from trachoma. This disease is more common in the schools than in the reservations, probably due to the intimate association of the pupils. As might be expected from the widespread prevalence of this disease, impairment of vision and blindness is quite common and the condition seems to be growing worse rather than better.

Measles and whooping cough are found to be quite widespread among the natives, while small pox and diphtheria are rarely met with. Not a single case of typhoid fever was found in the entire investigation—a rather remarkable fact considering the likelihood of a contaminated water supply arising from unsanitary habits.



The Department of Health recognizes that not only are the sanitary conditions existing among the Indians harmful to the natives themselves, but they constitute a serious menace to those of the white race who are in contact with them. This is very commonly the case and now that many reservations are being opened up to white settlements it would seem that an elaborate and far-reaching campaign to educate the natives in personal and domestic hygiene must be carried out before any marked improvement can be looked for.

It is doubtful whether much can be accomplished with the older generations, but well-directed efforts among the children in the Indian schools ought to be productive of good results in the near future.

G. H. W.

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#### THE ANNUAL MEETING OF THE AMERICAN INSTITUTE OF HOMOEOPATHY.

THE Denver meeting of the American Institute of Homœopathy proved to be an unusually harmonious and successful one despite the distance of the meeting place from the larger proportion of the members of the homœopathic school. The attendance was about equal to that at the last two meetings. Considerable interest was manifested in the financial affairs of the Institute, and President Hinsdale did a great deal toward placing them on an up-to-date business basis. It was decided to adopt the budget system in regard to the expenditures, and a definite plan of work for the Board of Trustees and the various committees was decided upon.

The report of the treasurer showed a larger balance than usual, which was a cause for great satisfaction.

The number of new members elected was three hundred and ninety-seven, the largest number ever taken into the Institute in one year.

The Committee on Conference with the American Medical Association that has been endeavoring to bring about a comparative test of the value of the homœopathic and other methods of drug treatment, reported that a favorable reply had been received to their communication.

The work of this committee will be continued and definite results are expected in the near future.

The resolution requesting all members of the American In-

stitute of Homœopathy to give up their affiliations with allopathic societies was laid on the table. The general feeling of the meeting, however, seemed strongly opposed to the old school affiliations on the part of the homœopathic practitioner.

Dr. DeWitt G. Wilcox, of Boston, was elected president without opposition. There are few practitioners of homœopathy who are unaware of the activity and interest that Dr. Wilcox has displayed for many years in behalf of the homœopathic school, and his enthusiasm for the cause coupled with his well recognized ability, eminently fits him for this responsible position.

The other officers elected were as follows:

First Vice-President, Dr. G. S. Peck, Colorado; Second Vice-President, Dr. Anna L. Varner, Wilkesburg, Pa.; Trustees, Drs. Ward, Sutherland and Hinsdale.

G. H. W.

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REMEDIES IN MALARIAL DISEASE.—In a recent discussion held at a meeting of the Homœopathic Medical Society of the County of Kings, N. Y., Dr. Freeman spoke of the remedies found useful in the treatment of malaria. Dr. Freeman has had much experience in the treatment of this plasmodial affection. He speaks about the value of both china (quina) and natrum muriaticum. In fact, since commencing practice Dr. Freeman states that he is only aware of three cases in his personal practice that have not been cured. The potencies usually used by him are the 30th and the 200th. The choice of natrum muriaticum is certainly indicated in a high percentage of cases as the positive effects of the attenuated drug on the healthy prover are—a feeling of general coldness; disposition to put on more clothing; chilliness without much, if any, sweat. Buzzing in the ears is another symptom elicited when performing the provings. The very high dynamizations have a wonderful effect in restoring vision in chronic asthenopia. It cures the symptom of spots in the field of vision. This high preparation has often produced in the prover sores in the mouth resembling aphthae.

LYCOPODIUM.—The characteristic symptom for this remedy in pneumonia is "fan-like motion of the nostrils," as Dr. Ad. Lippe gives it in his *Materia Medica*, or "fan-like motion of the alæ nasi in respiratory diseases of young people and children," as Dr. D. Wilson states it. These indications for its use in cases of bronchitis and pneumonia are of marked valuation. Respiration of great difficulty and orthopnea also call for the use of this remedy. A very good keynote is the mucous rattle, be the same evident in bronchitis or pneumonia. It has cough with difficult breathing—gasping for breath and stitches in the side of the chest. It is one of our sheet anchors in stabbing pleuritic pains.—*The Homœopathic Recorder*.

## Monthly Retrospect

### OF HOMOEOPATHIC MATERIA MEDICA AND THERAPEUTICS

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**CONDUCTED BY DR. DONALD MACFARLAN**  
**PHILADELPHIA**

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**FORBES ROSS AND CANCER TREATMENT.**—Dr. F. W. Forbes Ross, who has held a conspicuous place during the last decade in Great Britain in cancer work and who has very recently published in book form his researches of late years advocates, in the treatment of this dread disease, the use of potassium salts. He calls our attention to the untoward results obtained by the use of surgical intervention as well as by the empiric use of radium and X-rays. The salient point in his reasoning is that potassium is the salt of the cells and nuclei of all vegetable and animal tissue. This is universally true under conditions of health. Careful research has shown that the disturbance in epithelial cell growth, known as epithelioma, is entirely a matter of the disturbance of the nuclear function of epithelial and other cells in the body of man. It has been proved that this disturbance in the nucleus renders certain bodies, the chromosomes, deficient in number. Ross has observed that the potassium salts of the body during cancer become more and more diminished and scanty. We thus find that the red blood corpuscles in the course of a case of cancer suffer by reduction in number from five million to the c. mm., to only one million to the c. mm. Therefore, concludes the author, we should support Nature in her fight by introducing potassium salts into the attacked body. He closes his book with the statement that “assimilable salts of potassium, when administered in a bona fide case of cancer, will be found to benefit the patient in an astonishing manner, and will never cause the least harm or injury, even to the most feeble and exhausted sufferer.”

We doubt very much that Ross's theory will find many followers or that the cures which he asserts he has succeeded in effecting can be easily reproduced by his colleagues.—*New York Medical Journal*.

**THE GUIDE TO THE REMEDY.**—Anent this title there appears in a recent issue of the *Homœopathian* an excellent and very sedulously prepared article by K. N. Banerjee, M. D., of Barabandar, in the province of Bengal, India, Banerjee considers that the fundamental doctrine in homœopathic therapeutics is the doctrine of *individualization*, but even more fundamental is the idea of *the patient* from which it undoubtedly has sprung.

That man becomes sick primarily in the internals—in his will and un-



derstanding (intellect), which form the real individual—the *sickness* gradually *spreading from the innermost to the outermost* is the basic truth which has made homœopathy a distinct science of therapeutics.

The homœopathic physician consequently—

Views pathological tissue-changes as results or ultimates;

Looks to the first things to perceive connection and correspondence in a case of sickness;

Tries to perceive how the entire man has been changed, from first to last—from the mind to the tissues—*stamping his individuality upon that particular kind of sickness*;

Accordingly, looks for signs and symptoms that are *strange, rare and peculiar*, because these *relate to the individual* and not to the kind of sickness at hand.

These, again, in their totality furnish the healing-artist the means to understand wherein the patient can be changed, or in the language of Hahnemann: "*What is curable in him.*"

As is a sick man—a patient, so is a sick-making substance—a thoroughly proved drug.

The former stamps his individuality upon a case of sickness, making it quite distinct from every other case;

The latter also behaves similarly, for while it affects man in health through and through—from the mind to the hair and the nails—it has a *strange and peculiar* way of doing it, quite *different from any other drug* in the entire materia medica.

What is it but the inner nature of the drug—almost resembling the will and understanding of man—that has made it quite a distinct entity?

So it is that same vitalistic doctrine underlying the conception of the patient that explains the individuality of the drug. This individuality is expressed by symptoms uncommon, rare, and peculiar which in their totality distinguish it from all the others and enable the physician to perceive its capacity to change a similar disordered condition, or in the words of Hahnemann: "*What is curative in it.*"

By close individualization of the symptoms—

Of the patient and—

Of the drug, a homœopathic prescription is made according to—

The Law: *Similia similibus curantur*, the drug thus selected being the curative remedy.

From the very conception of the patient it follows that if he is to be cured thoroughly and permanently he must be cured *from the innermost to the outermost*—from cause to effect, from centre to circumference. In fact, that is the order of cure, as of sickness.

Thus the homœopathic physician determines the curative action of the prescribed remedy if the symptoms disappear—

1. From within outwards;
2. From above downwards;
3. In the reverse order of their appearance.

1. From within outward is from the innermost to the outermost—from the mind to the body. Speaking more externally, we say—

2. From above downwards—from the head to the extremities, from more important to less important organs or parts.

When eruptions appear on the skin and mind symptoms improve, or—Gouty swellings increase on the joints with amelioration of heart-trouble does it not demonstrate that the patient is being healed from above downwards—from the centres of life out to the circumference?

When a remedy takes the natural outward course it indicates that it is related to the entire patient from first to last, and that it has taken a deep hold on him.

3. When symptoms depart in this order it indicates that a thorough overhauling is in process within the economy under the searching action of the remedy.

The last symptoms were possible only because the first were not cured or were suppressed. They are off-shoots of the main stem and unless the axe has been laid to the root they cannot have shrivelled and withered. The first—or the old—symptoms then reappear on the scene only to reveal that the root is up and that it is a question of a few days or weeks for it, also, to shrivel and wither in turn.

The first and all succeeding symptoms to the last make up the complete image of a case and the appearance of the first, or old ones, followed by their final subsidence only illustrates the natural order of cure—from within outwards, from cause to effect, from centre to circumference.

The crude drug cannot reach the vital plane in which the real sick individual lies—the plane of disease-cause, and the remedy must be in a form subtle enough to operate on causes that lead to ultimates.

As ultimates cannot reveal the sick individual and we must go to the causes that have led to the ultimates, so also the crude form of the drug cannot reveal its inner sick-making nature hidden within its cause that has given it its form.

The inner nature is unfolded gradually by the process of potentization as the nearest approach to its cause or simple substance is made.

All causes are in the simple substance which exists only in degrees of fineness, for quantity can never be predicated of it; as the innermost of the patient has similarly the series in degrees, the remedy to correspond to this must also be administered in potencies of various grades or degrees.

[Dr. Banerjee is to be congratulated on this most excellent exposition of the Hahnemannian principle in the cure of disease. It is a masterful exposition, succinct, lucid and truthfully elaborated.]

OBSERVATIONS OF THE ACTION OF REMEDIES IN INTERESTING CLINICAL CASES.—Under the title above cited Dr. Rudolph F. Rabe, of New York City, delivered an instructive lecture before the New York State Homœopathic Medical Society in February last at Albany. Possibly one of the most interesting cases was one of diphtheria.

Some time last fall, there came to Flower Hospital a young woman whom examination showed to be ill from diphtheria. Immediate transference of the case to Willard Parker Hospital was made, where diphtheria antitoxin was employed with an uneventful recovery. Shortly after, during her convalescence, this patient noticed a weakness of the knees, as though they might give way, while standing or walking. There now fol-

lowed much difficulty of swallowing, with regurgitation of solid food and of fluids through the nose. The patient returned to Flower Hospital and returned to Dr. Rabe's ward. Examination showed a post-diphtheritic neuritis, with paralysis of the muscles of deglutition and absent patellar reflexes. Eating or drinking were practically impossible, and a loose tracheal cough added to the trouble. In these cases we naturally think of gelsemium, but no characteristic indications for its use appeared to be present. Accordingly, three doses of the nosode, diphtherinum in the c.m. potency, were given at intervals of twelve hours. Immediate improvement began, and within three days the patient was able to eat a hearty meal of solid food. Homesickness now claimed her, and in spite of the persuasive, gentle eloquence of the interne, Dr. Markham, the patient insisted upon going home. Within three weeks or less she was back, applying for admission to the Women's Medical Ward. This time her legs would not carry her, being altogether paralyzed, so that she had to be carried in and put in bed. But her throat was and had remained entirely well. Diphtherinum c.m., a single dose, was again given. In five or six days' time the patient was able to walk unsupported in the ward. At the present writing she continues to improve and has been given another dose of the remedy. There is every promise of a complete restoration to health within a short time.

The interesting features of this case are, of course, first the prompt response to a so-called nosode, the highly potentized toxin of diphtheria itself, after its antitoxin had been employed in the cure of the original disease. We believe it to be pretty broadly recognized to-day that diphtheria antitoxin, when it cures, does so by virtue of its immunizing power in supplying the necessary antibodies to oppose the toxin, elaborated by the diphtheria bacillus, and not by virtue of the law of similars. The use of diphtheria antitoxin, in other words, is not an homœopathic procedure, although von Behring himself has freely given credit to homœopathy and its principles for his discovery. But the use of the nosode diphtherinum is unquestionably homœopathic, since the symptoms upon which we prescribe it are identical with those typically produced by the disease. Nor is this a matter of isopathy, more especially since the highly potentized remedy can hardly contain any of the material disease substance, as is the case when an antogenous vaccine, for example, is employed. Had this particular case presented characteristic symptoms of, let us say, gelsemium, this remedy would have been curative and not diphtherinum. Of course, this nosode, like numerous others, needs extended provings in various potencies, upon healthy human subjects, so that its finer shadings may be brought out and its individuality more clearly expressed. At present, we know it almost altogether from its clinical side only.

The second point of interest in this case lies in its illustration of the workings of a true homœopathic cure and not a mere recovery. All real cures are made from above downward, from within outward, and in such a cure symptoms disappear in the inverse order of their coming. Thus in the patient under consideration, we see that the paralytic weakness of the knees was the first symptom noticed by the patient. It is, as has been shown, the last to get well. On the other hand, the paralysis of the pharyngeal muscles was the very last symptom to appear and the very first to improve.



This case is presented, therefore, as a slight contribution to our homœopathic literature of clinical demonstrations at a time when our able pathological workers are slowly but surely relating the modern vaccine and similar therapies to the parent of all of them, Homœopathy.—*The New England Medical Gazette*.

In the May issue of the *Revista Homeopatica*, the official organ of the homœopathic medical academy of Barcelona, appears a splendid article on "The Importance of Kreosote in Vomiting." It is the contribution of Dr. M. Moragas. The article is of great value in that he gives the indications for the use of this remedy in a concise and brief manner. The great fault in many of our materia medicas is the fault of a host of indications, many of which are unimportant and misleading. What is desired is a few reliable, trustworthy indications to bring before us the *salient character* of the medicinal agent. In this *most important* field Dr. Moragas is remarkable for the cogency of his insight. Cases of vomiting, diarrhea, odontalgias, and difficult dentition are the ones calling for this remarkable remedy. Kreosote in high attenuation is without doubt the most valuable remedy we have in cholera infantum, frequent green stools, and in the omni-present "summer complaint" of every day experience during the heated term in our great cities.—*Revista Homeopatica*.

QUININE AMBLYOPIA AS A GUIDE TO CHININUM.—In an original communication to the *Charlotte Medical Journal*, Dr. Edward E. Gibbons, of Baltimore, speaks at length on the ocular complication of malarial disease as well as the eye condition following the action of quinine. Dr. Gibbons asserts that the diagnosis of malarial amblyopia or amaurosis is not usually difficult save in cases in which a doubt arises whether the blindness is due to the malarial infection or to quinine poisoning. Quinine amaurosis could only be confounded with the permanent form of malarial blindness since the former has always a long course. An ophthalmoscopic examination will however always reveal the true nature of the case. *In poisoning with quinine there is always a decided ischemia of the retina and optic nerve. The arteries and veins are extremely attenuated; all traces of them may even be lost a short distance from the papilla. The optic disc from the onset is very white and its margins very distinct as in cases of optic atrophy. There are furthermore no evidences of retinal hemorrhages.*

[This toxicologic picture, if seen in our patient, will at once call for our dynamized preparation of china (quinine).]

Malarial amblyopia is associated with just the reverse condition. We find hyperemia of the fundus and papilla, optic neuritis and retinal hemorrhage or arteritis; a picture wholly unlike that of quinine amblyopia. In exceptional cases I have noticed narrowing of the retinal arteries but the veins are never attenuated, but more or less turgid with blood. Malarial amaurosis is of brief duration and frequently ends in complete restoration of vision unless atrophy of the optic nerve ensues. Quinine amaurosis runs a much longer course and while with appropriate treatment useful central vision is regained the field of vision for ever remains contracted so that while the patient is able to read and write he is not in condition to safely go about alone. The ophthalmoscopic picture remains about the

same and the amount of vision slowly wanes parri passu with increasing atrophy of the optic nerve. Suppurative choroiditis, tritis and cataracts are infrequently associated with acute malaria. A few such cases have been reported.

The eye complication of chronic malaria are also found in the retina and optic nerve as retino-choroiditis and optic neuritis. In the former there is peripapillar edema and venous congestion accompanied by numerous retinal hemorrhages scattered well over the fundus, small and punctiform in the periphery but large and irregular in outline about the optic disc. Poncet studied microscopically the eyes of those dead with malarial cachexia. He confirmed the above findings but did not find any melanaemia in the retinal circulation but the retinal hemorrhages were associated with proliferation of the endothelial cells of the capillaries. In the choroid the melanæmia was however distinctly noticeable.—*Charlotte Medical Journal*.

MAGNESIA MURIATICA.—This salt of magnesium was proved by Hahnemann, and its pathogenesis appears in the Chronic Diseases.

It has an influence on the liver, and is indicated in chronic liver affections, such as congestion, enlargement and induration of that organ; the indicating symptoms are tenderness over the liver region, and pain extending to the spine and to the epigastrium, and which is worse after food. There is flatulent colic and constipation. The liver pains are aggravated by pressure and touch, and from lying on the right side. The tongue takes the imprint of the teeth and feels as if burnt or scalded. There is usually little or no inclination for stool and much effort is required for a small result. The characteristic stools are of large, dry masses that crumble at the anus, or small knotty stools like sheep dung, which may be covered with mucus.

There is likewise difficulty in expelling the urine, and the bladder can only be emptied by straining and bearing down with the abdominal muscles, or by pressing with the hands over the hypogastrium.

The magnesia muriatica patient is nervous and excitable, especially at the period of menstruation, and is liable to have nervous headaches, hysterical spasms or globus associated with that function. The menses are black and pitch-like, with pain in the back when walking, pains in the thighs when sitting.

A peculiar symptom of magnes. mur. is palpitation while sitting, relieved by moving about. Magnesia muriatica is present in sea-water in considerable quantities, and is useful for evil effects arising from sea-bathing. The patient's symptoms are generally worse from sea-bathing. Most symptoms are better in the open air, except the headache, which is better indoors and from wrapping the head up warmly.—*Dr. T. G. Stonham.—The Homœopathic World (London)*.

# THE HAHNEMANNIAN MONTHLY.

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## SKIN MANIFESTATIONS OF DISEASE IN CHILDREN.

BY

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(Read before the American Institute of Homœopathy, July, 1913.)

INSPECTION is an important keynote in the examination of any child, sick or well, because it teaches us so many things that might be otherwise overlooked, especially in dealing with a patient unable to describe symptoms. All sick children should therefore be stripped, and the condition of their skin observed by the physician.

In noting the color of the skin either of two conditions is prominent, pallor or cyanosis. First let us consider pallor. A pale face may or may not indicate a true anemia, and a high color may exist with a low hemæglobin percentage. Here more stress should be placed upon the condition of the mucous membrane. In different types of anemia the color varies, as in chlorosis or simple anemia it is greenish yellow or almost waxy white, in pernicious anemia it is lemon yellow, and in secondary anemia it has a peculiar earthy tint. In leukocythemia it has a muddy appearance.

In acute nephritis the skin is white and if œdema is present it produces the characteristic pasty pallor. We see the pallor early in parenchymatous nephritis, while in the late stages it has a brownish hue. Early in interstitial nephritis we find a ruddy appearance indicating to the casual observer health, but this in the late stages becomes the peculiar fawn color. Also in cardiac diseases, especially aortic regurgitations we are often deceived, as there is rarely any marked true anemia.



Cyanosis, either general or local, suggests a number of underlying causes whether dyspnea is associated with it or not. It indicates obstructed venous return, deficient oxidation or some diseased condition of the heart or lungs, as asthma, emphysema, presence of some foreign body, croup, diphtheria, bronchitis, pneumonia or pleurisy. Spasm of the diaphragm may produce marked cyanosis. Congenital heart disease is a most important cause. Certain drugs may account for an otherwise unexplained cyanosis.

Jaundice is only a symptom and may be due to a number of different causes. Obstructive causes, are stricture or obliteration of the ducts, inflammation of the ducts as in catarrhal jaundice, foreign bodies in the ducts as roundworms, and pressure on the ducts from an enlarged gland or tumor. The toxic forms are sometimes seen in scarlet fever, malaria, Weil's disease and other infectious diseases. In cases of jaundice the color of the skin may vary from a dim or brilliant yellow to a deep green or bronze. Icterus neonatorum in mild cases occurs during first 24 or 48 hours, and lasts for a week or two. It is benign and unimportant. The grave form is due to sepsis usually from the umbilicus, syphilis of liver or congenital absence of ducts and is often associated with hemorrhage from the navel and is a fatal disease.

Hyperidrosis of the hands or feet may indicate idiosyncrasy, debility, neurasthenia and sexual neurosis. Unilateral sweating especially of the head or face occurs in pressure involvement of the sympathetic. Sweating of the head is a frequent symptom of rickets. General sweating occurs at the crisis in certain acute diseases, severe pain, collapse and phthisis. Anidrosis or dry skin is often associated with those diseases which cause a profuse discharge of fluid by the bowels or kidneys as in diabetes.

Oedema may be either local or general. In the first instance it is confined to the actual connective tissues, while the latter is called anasarca, which is a combination of oedema and dropsy. It is easily recognized by its swelling, which receives and retains indentations from pressure of the examiner's finger or constriction due to clothing. General oedema is limited to practice to Bright's disease or a failing heart. In heart disease the oedema generally commences in the feet and extends upwards. In Bright's disease it appears first in the face and eyes and extends downwards. In children with Bright's dis-

ease we get the so-called marble oedema of the legs due to the blue superficial venules, contrasting with the dead white of the skin. Local oedema may, but does not occur over all purulent exudates or suppurative inflammation as empyema, mastoiditis, etc.

Subcutaneous hemorrhages may be the result of an ordinary bruise or may occur in connection with acute infections or chronic diseases associated with cachexia. When it accompanies an acute infection it indicates an exceptionally severe type of the disease. Such is seen in typhoid fever, whooping cough and measles. Of the chronic diseases it is seen most frequently in cases of scurvy, pernicious anemia and leukaemia, as well as being a complication in many other diseases.

How often we meet with the exclamation, "My child is peeling. What is the cause?" The chief diseases which desquamate are scarlet fever, measles, small pox, erysipelas and dermatitis. Each disease has its peculiar flake, scale, or crust.

Scars should be studied as to their history. I shall merely mention a few causes: Small pox, zoster, syphilis, bed sores of typhoid, bullet and stab wounds, tuberculosis, surgical operations, etc. Calluses usually indicate work or wear. Nodules may be seen in connection with rheumatism. Tumors, inflammatory or not, must be distinguished as to cause and location. Parasites especially crab-lice and worms all have their characteristic lesion as well as an individuality. I shall leave the true diseases of the skin itself to the dermatologist. Thank you. References:

Cabot's Physical Diagnosis.

Greene's Medical Diagnosis.

Rurah's Diseases of Children.

Rotch's Pediatrics.

Holt's Diseases of Infancy and Children.

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## IS DIAGNOSIS A NECESSITY IN ORDER TO APPLY THE REMEDY HOMOEOPATHIC TO THE CASE?

BY

E. P. MILLS, M. D., OGDEN, UTAH.

(Read before the American Institute of Homœopathy, July, 1913.)

HERE we have a question put up to us for an answer, shall it be aye or nay? The answer which each one of us would

emphasize will depend on our individual training and our varied experiences. For I take it that we all will want to emulate the old time Populist and take the middle of the road ready to jump to right or left as the present moment indicates.

What do we mean by diagnosis? Dorland's dictionary defines it thus:

- I. "The art of distinguishing one disease from another.
- II. The determination of the nature of a case of disease."

Art, mind you, not science, not even to-day with the great development of the laboratory, the exactness of the microscope and the delicacy of the chemist's reaction, will any one wish to write into that definition the word science.

All of us know how often the findings of the autopsy, and in a minor degree the operating table, reveal conditions unsuspected by the attendant, and the absence of pathology that was strongly suspected beforehand.

Then the second clause of our definition, the nature of the illness. We must needs know of ultimate causes of things as well as the naming of diseases. To say that our patient has an arterio-sclerosis is not enough for us, we must know what is behind that condition. What is the nature and origin of the poison which by its absorption is causing that overgrowth of the fibrous framework of the walls of the vessels, and the hydra-headed symptoms which result? Is it from senility purely, alcohol, narcotics, lead, or from toxins elaborated in a clogged alimentary canal?

These factors also are hard to be solved and not infrequently do we stand baffled before our problems.

What shall we do then when science can give us—with our limited knowledge—no positive answer, and our art is handled with such poor skill that we can gain not even a probable solution of our conundrum? Shall we fold our hands and wait developments, or use a hypodermic as a concession to our ignorance?

Here is where we will answer yes to the question of our title. The homœopathic materia medica with its wealth of observations of the reaction of healthy tissues to the presence of remedial substances furnish us many a solution to perplexing situations.

The old time homœopaths without modern training, without microscope, or the delicate tests of the laboratory workers, many times stayed the progress of disease they knew not, and



even waved back the approach of Father Time and his scythe. This by symptom matching, if you please. By laboriously noting the many objective and especially the subjective deviations from health, the modalities and the mental states and comparing the picture thus outlined with those recorded by Hahnemann and the other early provers, they wrought their miracles and laid strong and wide the foundations on which we are now building. All honor to all such!

But what of us to-day? Shall we ignore the toil and travail of the many who have sought to find the truth and who have brought to us new and valuable methods of diagnostic skill? Shall we reaffirm our faith to that which is old and resolve that which was good enough for our fathers is good enough for us, and relying on the admitted superiority of our *materia medica* stand or fall by the diagnosis of the remedy and ignore the diagnosis of the disease?

No, not if we want to maintain our own self-respect and if we want to honor the name we bear.

The homœopathist has a harder task to perform than the other practitioners. If he is to be honest and faithful to his patrons, he must do his best to diagnose his case, to determine the causes working under the surface; and then he must just as carefully diagnose his remedy.

In order to illustrate the point I desire to make, will you bear with me in the recital of several hypothetical cases—some are real experiences.

A woman of three score years gives as the most prominent presenting symptom, very large, hard glands on both sides of the neck. Shall we compare *iod.*, the *calcareas*, *sil.*, *carbo anam.*, and the host of other remedies that have caused and cured glandular enlargement, or shall we apply locally, as was done, agents to produce a change in the glands? First of all we had better examine the throat and post nasal space to see if we can determine the cause of the glandular enlargement. A large sarcoma of post nasal origin reveals itself. The remedy we now prescribe may be the same as was indicated before the fact of the malignant nature is known, but the prognosis and general treatment are very much changed.

Suppose we have a child of from 6 months to one and a half years old, crying and giving evidence of colicky pain in the abdomen, and whose chief presenting symptom is a bloody discharge with much tenesmus. Is this a case for *merc. cor.*, or

for one of the 84 remedies Boenninghausen lists as having bloody stools, 62 of which also have tenesmus? Perhaps so, but we also find a tumor, sausage shaped, in the upper part of the abdomen. Now in the face of a diagnosis of intussusception are we willing to stake our all on the homœopathic remedy, no matter how well chosen nor in what potency? Here again we answer no.

That this may not be tiresome let me tell of one more case. A young married woman, with or without the history of pelvic inflammation, comes to us, if she be fortunate, with this history; some two months before she missed a period, and had the usual symptoms of the early weeks of pregnancy and hopes delayed maybe by years of sterility are awakened, she now reports that for two or three weeks she has been having a very slight bloody discharge almost daily—no more than a spotting, on questioning she tells of pain more or less vague in right or left side. In the face of this history are we to search our repertories for remedies with pains in pelvic regions and those that have inter-menstrual flows, and construct a picture of the case from the likes and dislikes, the complexion and the suppressed skin eruption of childhood days? A pelvic examination will reveal a tender mass out from the body of the uterus and the diagnosis of an extra-uterine pregnancy becomes very probable. Only one remedy remains to be considered, ferrum met. low, and a sojourn in a hospital is the only thing we can consider without being criminal in our negligence, and that, even if operation reveals some other condition than that suspected.

Dr. Wood presented a classic to the Institute under the title of the "Tragedy of the Gonococcus," and as was pointed out in the discussion the tragedy fell not to that irrepressible cocci but to the innocent bystanders. Some gifted pen could give us an equally valuable paper on the "Tragedy of the Diagnosis," or rather the non-diagnosis.

Now to hear the conclusion of the whole matter. A homœopathic prescription may be made without a diagnosis, but if as honest men and women we want to retain the respect for the individual with whom we have to live our active lives—ourselves—we must do our very best to diagnose all our cases.

## Transactions of the New Jersey State Homœopathic Medical Society.

SIXTIETH ANNUAL SESSION.—MAY, 1913.

### A CLINICAL STUDY OF PNEUMONIA IN CHILDREN.

BY

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(Read before the New Jersey State Homœopathic Medical Society, Montclair, N. J., May, 1913.)

THE fact that pneumonia in childhood is frequently overlooked or confused with other conditions is sufficient reason for presenting this subject for discussion. I shall confine my remarks to an analysis of the symptoms and physical signs upon which we must rely in making a diagnosis of pneumonia and in differentiating it from those affections to which it may bear an outward resemblance.

In the first place, how can such a serious malady as lobar pneumonia escape detection? Broncho-pneumonia, on account of the cough, dyspnoea and diffuse chest manifestations, is rarely overlooked excepting that secondary form of broncho-pneumonia which begins insidiously in infants suffering from ileocolitis or some other exhausting disease which may exist without cough, the primary ailment masking the symptoms. Lobar pneumonia, however, frequently runs its course unsuspected. Its onset with vomiting or convulsions; the predominance of cerebral symptoms and perhaps the absence of cough throw the physician off his guard and cause him to neglect making a thorough daily examination of the chest. Sometimes the fever and associated symptoms are ascribed to teething and the chest is not examined for this reason. Many times, however, careful routine examination of the chest fails to reveal rales, dulness or bronchial breathing and the diagnosis of pneumonia is excluded on these grounds. Let us therefore discuss in detail the peculiarities of pneumonia in childhood and get them clearly fixed in our minds.

In infancy pneumonia frequently begins with vomiting, as-



sociated with pronounced abdominal distention and evidences of abdominal pain so that the picture is one of an acute milk infection or of an enteritis rather than of pneumonia. It is true, the child breathes rapidly and the respirations may be grunting in character but an examination of the lungs at this stage is frequently negative and so the diagnosis of enteritis is made. As there is no cough, or the cough is so insignificant as not to attract attention and the stools either become loose spontaneously or are so as a result of laxatives and contain mucus and curds, this error is easily explained. Only too often the lungs are not examined in a routine manner and the pneumonia is never suspected even if consolidation occurs. In other cases daily careful percussion and auscultation of the chest may reveal nothing until the fifth, sixth or seventh day.

In older children the abdominal symptoms simulate appendicitis so closely that the two conditions are repeatedly confounded. Many children have had their abdomens opened at the height of a lobar pneumonia under the belief that they were suffering with appendicitis. A thorough painstaking examination of the chest in all cases of suspected appendicitis in children, especially when the onset has been with high fever and chill and the respirations are disproportionately high will be an effective check to this serious error. Naturally, in these cases the lesion will be found at the right base. Aside from this appendicitis-type, however, I have seen children taken violently ill, apparently from severe acute indigestion, after some indiscretion in diet with vomiting, fever, epigastric pain, obstipation and marked prostration. Here the error in diet and onset of the pneumonia were a coincidence. Pneumonia was not suspected but was discovered during a routine examination of the chest.

The clinical picture of pneumonia in young children is to my mind so characteristic and clear cut that we can hardly go wrong in making a diagnosis if we give it full recognition. Physical examination may at times tell us that we have no evidence of consolidation, that we have simply the signs of bronchitis, or that there is but a suspicious impairment of resonance and impairment in the purity of vesicular breathing in a small area, however, subsequent developments, namely, the advent of a crisis, or the later appearance of an abundance of rales at some site in the chest or a demonstrable area of hepaticization of the lung will show us that we are correct in making

a diagnosis of pneumonia. Again the X-ray will frequently come to our assistance and demonstrate physical changes in the lung that had escaped our skill in physical examination. This is especially the case in central pneumonia which begins at the hilus of the lung and slowly spreads outward toward the pleura and in tuberculous pneumonia in which small scattered areas radiating from the hilus may be seen in the skiagram before they have produced distinct physical signs.

In such cases as these, however, we have practically the same symptoms as in the cases showing early physical signs, namely, a temperature range that is too high and too persistent for simple bronchitis; a respiratory rate disproportionately high, and a characteristic grunting or moaning expiration. Sometimes this jerky respiration in which there is a momentary pause after inspiration is mistaken for a straining effort at stool, especially in cases with marked abdominal distention, but it is too rhythmical and short to indicate any such purpose. Cough may be an insignificant symptom. In fact it may be absent in the first days of a central pneumonia not appearing until pleural irritation supervenes or until resolution sets in. In the early stages it is dry and hacking, later becoming loose. When there is an associated pleurisy it is short and suppressed, the child usually becoming fretful as the desire to cough comes on, trying to suppress the same and crying after coughing. And lastly, there is almost invariably the fan-like motion of the alae nasi and the circumscribed redness of the cheeks which in conjunction with the above symptom complex, make out a clear case of pneumonia irrespective of the physical signs.

Another peculiarity of pneumonia of which I wish to speak is the cerebral symptoms frequently associated and sometimes presenting great difficulties of differentiation from actual meningitis. As a rule the distinction between toxic meningeal irritation, or meningismus and meningitis can be made but often this is impossible. The attack may begin with convulsions, retraction of the head, stupor, vomiting, exaggerated reflexes and Kernig's sign, but there is no evidence of involvement of the cranial nerves. The discovery in such cases of a lobar pneumonia makes us feel decidedly more hopeful than when these symptoms exist without indications of pneumonia. If the symptoms have been purely toxic they promptly disappear with the advent of the crisis, but if they persist after this time or if the crisis is delayed we must change our opinion as to

their significance. Again, if cerebral symptoms occur late in the course of a pneumonia instead of at the onset they are more likely due to a metastatic infection of the meninges rather than to toxæmia. Under these circumstances lumbar puncture should be performed.

The rigidity of the neck in basilar meningitis is more pronounced and involves the muscles of the neck more prominently than in pneumonia. In fact, in pneumonia of the upper lobe the retraction of the head may be more apparent than real, being only a painful reflex fixation of the shoulder blades from irritation of pleura.

That which holds good in the case of meningeal complications also holds good with the peritoneal cavity and so we must not lose sight of the fact that an actual peritonitis may develop during the course of pneumonia. These cases are very grave and usually prove fatal. Complete absence of peristaltic sounds is an important sign in the diagnosis of this condition. Heubner has called attention to the fact that in infancy a pneumococcus polyserositis may develop with involvement of pleura, pericardium and peritoneum.

Perhaps the commonest and clinically most important complication of pneumonia in early life is empyema which occurs in about ten per cent. of all cases. The effusion may be metapneumonic, in which case the pneumonia first runs its course, terminating by crisis, but the evening temperature remains elevated and gradually becomes higher so that the typical pneumonic course with its continuously high range terminating by crisis is followed by a remitting or septic type of fever indicating the appearance of pus in the pleural cavity. Such a temperature range is very suggestive of empyema and if the chest shows signs of flatness at the base or it may be a circumscribed area of lingering dulness with diminished vocal fremitus and feeble or even bronchial breathing we should aspirate the chest at this point. If pus is found, drainage of the pleural cavity should be instituted.

Pus may collect in unusual locations making its detection difficult. It may become sacculated through adhesions and be walled off high up in the chest under the shoulder blade or in the axillary region or it may be interlobar. In such cases an X-ray is of decided value in helping us locate the pus. It may also be confined to the mediastinum and thus produce alarming symptoms. I recently had a case under my care in which



the pus collected anteriorly in the upper chest after an attack of pneumonia of the right upper lobe, encroaching upon the mediastinum and producing compression of the right bronchus and of the right innominate vein with resulting swelling of the right arm and right side of the face and neck. The chest was drained in the third intercostal space at the border of the sternum and the child—eight months old—made a perfect recovery.

The *diagnosis* of a typical case of pneumonia is not difficult, as this resume of its clinical manifestations indicates. A tentative diagnosis can be made early from the symptoms mentioned as characteristic, namely, abrupt onset with persistent high fever, disproportionately rapid respiration with moaning expiration, fan-like motion of the alae nasi and dry cough. Later on the physical signs in the chest will verify the diagnosis. Many cases, however, are not typical, or are so obscured by complications or the predominance of the abdominal or cerebral symptoms that they will require most careful study to identify them.

The fever, for example, may be remitting in type. I have seen it range from 99° F. to 106° F. for several days before the pneumonic changes could be demonstrated. This is especially common in influenzal pneumonia.

Lobar pneumonia may, in the beginning, be confused with broncho-pneumonia. The latter is a diffuse, in fact an actual parenchymatous inflammation of the lung involving the smaller bronchi as well as the air cells and interalveolar structures. It may be of such acute onset and prove so rapidly fatal that only at the autopsy can the differentiation be made, but usually it is more gradual in onset than the lobar type, the bronchitis is the predominating feature and the areas of consolidation occur in patches and do not conform to the outline of the lobe.

The outline of the area of dulness is a most valuable diagnostic sign and greatly aids us in differentiating a consolidation from an effusion. If an anterior or middle lobe is involved the dulness is entirely in the anterior aspect of the chest and the lower axillary regions will be resonant. Posteriorly there will only be appreciably dulness in the apex and supra-spinous fossa. When the lower lobes are involved the dulness extends from the third dorsal spine downward taking in the entire posterior aspect of the chest along the spinal col-

um but not running transversely across the chest to the axillary region. The reason for this is explained by the fact that the upper border of the lower lobe is an oblique line running from the third dorsal spine downward and forward as far as the sixth rib anteriorly. The axillary region therefore above the sixth rib remains resonant in consolidation of the lower lobe. In case of fluid, however, the dulness does not extend upward as high posteriorly, excepting in the case of very large effusions, but in the lateral regions it reaches even a little higher than posteriorly, so that dulness high up in the axillary region associated with flatness posteriorly speaks in favor of fluid and against consolidation.

Besides these differences in the area of dulness we will find a distinct difference in the tactile perception elicited during percussion, namely, the sense of resistance encountered in exudations and the flatness of the note. Vocal fremitus is also diminished. Auscultation may give us confusing information for at times distinct bronchial breathing is heard over fluid accumulations although in large, free effusions we will generally get diminished breath sounds or distant, muffled bronchial breathing.

At times we encounter cases in which an active pleuritic process coexists with pneumonia. These cases are serious as a rule and present a high mortality rate. There is pronounced toxemia, great distress from pain and dyspnoea; the symptoms are those of pneumonia while the physical signs point to effusion. Aspiration is often negative because of the predominance of fibrinous exudate.

In consolidation of a lower lobe distinct tympanitic dulness can be demonstrated anteriorly in the upper lobe of the corresponding lung. Often it is possible thus to locate the affected lobe before turning the child over for percussion of the back. A similar change of the percussion note also occurs in the affected lobe at the onset of the disease. Associated with this there is a diminution in the intensity of the breath sounds with associated increased respiratory murmur or puerile breathing in the uninvolved lobes. The significance of these physical signs is strengthened by the presence of crepitant rales in such an area but unfortunately rales are frequently absent at this stage.

The X-ray is a distinct aid in the diagnosis of pneumonia, especially of central pneumonia and in differentiating consoli-

dation from fluid. In the latter case the horizontal line of the shadow and the displacement of the heart are the most important points indicative of effusion.

As to the value of the X-ray in detecting consolidation originating at the hilus and not yet extending to the surface there is still some difference of opinion. Certain French clinicians, notably Apert (*Maladies des Enfants*) do not recognize a central or partial pneumonia but believe that in cases lacking distinct evidence of consolidation there is a *pneumonie sans hépatisation* as proven by the X-ray examination.

Von Pirquet, on the other hand, speaks of the value of the X-ray in demonstrating the presence of exudation in the region of the hilus in such cases. (*Lehrbuch der Kinderheilkunde*; Feer.)

My personal experience leads me to agree with v. Pirquet on this point, for I have frequently seen the X-ray reveal areas of consolidation that escaped detection by physical diagnosis, and have also seen it reveal a consolidation several days before physical signs were demonstrable. The following case well illustrates this point: Mary M., aet 8 years, was taken suddenly ill with a chill followed by high fever and rapid respirations. She was seen on the third day of her illness, and pneumonia was suspected, but could not be demonstrated. On the fourth day an X-ray plate was made which revealed a distinct shadow in the centre of the right upper lobe. The following day dulness and bronchial breathing could be demonstrated and the entire lobe gave distinct signs of consolidation by the seventh day.

#### DISCUSSION.

DR. SIMONSON: Dr. Raue has covered his subject so thoroughly, as he usually does, that I have nothing left to say except "Amen." I am very much interested in pneumonia in infants, principally from a diagnostic standpoint, not that I am uninterested in the treatment, but the difficulties of diagnosis in some of the atypical cases are sometimes very marked. I think that at times most of us have been put in a very embarrassing position in the eyes of the layman, by exhibiting doubt as to the diagnosis between a pneumonia and a possible meningitis.

There is practically nothing to add to what Dr. Raue has said, except to touch on some diagnostic points. I think one



of the reasons the pneumonia signs, the physical signs, are not elicited in under three or four days sometimes, is because there are *not present* in the case two or three little points that would enable us to make a diagnosis. One of my own points for early diagnosis is the character of the rhythm of respiration, Dr. Raue has spoken of the usual rhythm with that grunting respiration that ceases at the end of inspiration. Many times you will get that without having the little grunt, or any sound made by the child at all, except the normal respiratory sound; but if you will listen over the affected area, with or without a stethoscope, whether you can demonstrate consolidation in any other way or not, you get a little faint whistle, a very short stop at the end of inspiration and before expiration begins, also a prolonged respiratory tone of a higher pitch than in any other part of the lung, and it is by the pitch of that respiratory tone that I make the diagnosis. I have demonstrated that many times and have made diagnoses of pneumonia several days before you would get any evidence of consolidation by percussion. As to the symptoms shown, subjective symptoms, it is most surprising how different symptoms will be in different cases; in fact, many of them will have none at all. The week before last I saw a case in consultation, a little child four years old, running a temperature of 104 to 104½ at night, with apparently no other symptoms of pneumonia, apparently perfectly well, respiration not over thirty, and with good appetite. The family physician, when I made a diagnosis of probable pneumonia insisted that I must be wrong. He said he thought it was typhoid. He made a blood count, and found twenty-three to twenty-four thousand whites, which, of course, contraindicated typhoid; blood analysis did the same thing. After four or five days I saw the child again and there was positive evidence of consolidation in one of the lungs. That will happen frequently.

It is the unrecognized case of pneumonia, with its small unresolved areas, which provides such a perfect culture ground for the tubercle bacillus. I am convinced that primary pulmonary tuberculosis, as a result of this class of cases, is much more common in young children than the text books would lead us to suppose. Many a case will go through a lobular pneumonia with the pneumonic symptoms absolutely unrecognized.

Another thing: it must be remembered that localized bronchitis is always to be considered. A localized bronchitis is practically always pneumonia. Again, the cerebral symptoms are im-

portant. Many cases of pneumonia are undoubtedly carried to a successful conclusion under the name of meningitis, and results are claimed in the treatment of meningitis with absolutely no basis whatever. The diagnosis is the difficulty, but there are one or two points. One of those is the lowered respiration, which you are going to get if meningitis is present, even though you have pneumonia present. That is number one. And another good point is the irregularity of respiration. In pneumonia, while you get the increased rate of respiration, you do not get the irregularity. In meningitis the respiration is always more or less irregular if closely watched. I don't hesitate to do a little puncturing, even if the child has pneumonia.

There are one or two other points that have interested me. One is nephritis. After your child has apparently recovered from the pneumonia—the crisis past—and the temperature goes down, and afterward you get a fever rise, the things you are going to think of are, of course, an unresolved pneumonia or only partially resolved pneumonia, a prolonged pneumonia, pyelonephritis, otitis media. One point is useful—when I don't know whether it is otitis media, pneumonia, nephritis of the kidneys, I look first for nephritis, pyelonephritis. I don't mean ordinary nephritis, with a little bit of albumen and with casts and high specific gravity. You get those in all febrile cases. But I mean pyelonephritis, as shown by the character of the epithelia present. I have seen quite a number of cases where there was pyelonephritis present. It is the same way with chicken pox. In chicken pox, it is not usually supposed or understood, we are very apt to have pyelitis with our chicken pox, sometimes actually looking very like nephritis. Chicken pox is usually looked upon as harmless disease, and it is, with that one exception.

Another point is the leucocyte count. I have seen several cases of empyema with normal leucocyte count. There was sent to me some time ago one of these puzzles. It had been diagnosed as empyema, but the leucocyte count was absolutely normal; and the surgical staff opened up the lung and took out a section of rib, and there was no pus in there. The child had no temperature, for quite some time, no increased leucocyte count, perfectly normal respiration; but it had all the physical signs of fluid in the chest and in the upper part of the chest, coagulated empyema. A number of days after, the child began to run a temperature that was very high, after six or seven days pus began to show in the breast, then the tempera-

ture went up and the leucocyte count went up. Many of these cases are very puzzling indeed.

One more thing and I am through. This question of prolonged pneumonia—chronic pneumonia—I have a case now of chronic pneumonia, absolutely non-tubercular, for over a year, a year and a half. It will have these little regular attacks of pneumonia every two or three months; no pus, no fluid in the chest. It is one of those rare cases of chronic consolidation of the lungs, non-tubercular.

To my mind, the question of diagnosis of the pneumonia is the most important part. The treatment is comparatively simple after that.

DR. YOUNGMAN: I am surprised at Dr. Simonson's statement that the leucocyte count was so unreliable. I have found it quite reliable. I have had several instances, in the determination between cases of typhoid fever and pneumonia. In one case, particularly, two physicians who saw the child insisted it was a case of pneumonia, and another one said it was typhoid fever. The leucocyte count was made, and because of the low leucocyte count typhoid fever was diagnosed, and subsequent developments confirmed the diagnosis. And so, in empyema. Very often, in empyema, particularly if it occurs rather early, it is difficult to diagnose between the accumulation of pus and consolidation. You listen to the lung and you hear the pneumonic breathing, you hear rales in the bronchial tubes, you think you are listening to the pneumonic area of the lung when really you are listening to the accumulation of pus. I have found—in fact, I think Dr. Raue speaks of this in his paper—the necessary thing to do is to have a very carefully prepared chart, time chart, made every two hours, and watch, and when you have got this for the first twenty-four hours, on the next day at the time at which it began to ascend, have your nurse watch and see if the child has rigors or chill or cold nose or cold toes.

DR. CORNELL: I would like to say, before discussion is closed, that I have been very fortunate to see several splendid X-ray pictures taken by Dr. R. in this condition. It was certainly very interesting to see the condition shown up in the picture, especially where the diagnosis was somewhat doubtful, from the physical examination. I also would like to say, or make a plea, with Dr. Raue, that the general practitioner should use his stethoscope more frequently in his work with children. In any case of continued high fever, where the diagnosis cannot be made absolutely from some other symptoms I know it



is sometimes hard with a fighting child, and more especially hard sometimes with a fighting adult. We don't care about the fight of the child, but I have sometimes found that the mother was not willing to have the child disturbed or the chest bared for fear that the child will take cold, and so on, and maybe the doctor is in a hurry, and he is going to make a diagnosis of something else, and so on, and he will overlook conditions that would be perhaps apparent through the use of the stethoscope and a little more care and time.

DR. SIMONSON: I think Dr. Youngman is laboring under a misapprehension regarding my opinion of the reliability of the leucocyte count. I refer more particularly to sacculated empyema, where there was no absorption of pus.

DR. FOSTER: I did not hear the paper, but I want to make a plea for the more frequent and free use of the hypodermic needle. Many of these cases will be cleared up readily by the use of the hypodermic needle; in fact, more speedily than with the stethoscope. In every case where consolidation does not clear up in due time I don't hesitate to put a large sized hypodermic needle in, under aseptic precautions.

DR. WESTNEY: I worked for over a year with Dr. Sharpless Hall. He once said, "When the doctors die, they do not have Hell so much to fear as they do the forms of those who have gone to Heaven before them, taken with the empyema that the doctors did not recognize." I think there is a great deal of truth in that. Many of us do not recognize these empyemas.

DR. RAUE: I don't want to take much more time; but I want to answer a few questions, and there are one or two points I would like to make just a few remarks upon. In the first place, as Dr. Youngman said, I should have the temperature taken frequently in these meta-pneumonic fevers, meta-pneumonic rises in temperature, and look for rigors. Very frequently, as he said, the child will have cold nose or fingers. In the majority of cases of rigors the chill is a rather insignificant symptom; it has to be looked for, or it may be absent. On the other hand, there are a number of cases in which the chill is so prominent, you do not suspect pneumonia; you say it is malaria. I have seen such cases, with regularly recurring chills; if the blood had been examined you would never have suspected malaria; the trouble was in the chest. But this chill

coming on at regular daily intervals, this malaria picture, is often associated with pus in the chest.

Apex pneumonia—I think I would rather call it pneumonia of the upper lobe, because the entire lobe is usually involved—is quite common. I should say in the children's hospital during the winter we have usually anywhere from three to eight cases of pneumonia continuously during our service there, probably at least fifty or sixty yearly, at least ten per cent of them are upper lobe cases. In fact, we examine the upper lobe as frequently as the lower lobe. We expect to find a good proportion have involvement of the upper lobe.

I have some very interesting X-ray pictures which I neglected to bring along. One shows a rather unusual condition, involving both lobes, pneumonia of both upper lobes. On the physical examination we rather questioned it, but the X-ray picture verified the diagnosis. You can have both upper lobes involved at the same time.

Perhaps I have given the impression that every case of pneumonia has these prominent symptoms which I have presented, but that is not the case. Probably one of the reasons why pneumonia is so frequently overlooked in infancy is because so many of them do not appear to be sick enough. You are surprised to find the child sitting up, eating, and seemingly, quite well, but if you will listen, you find consolidation in one of the lobes of the lung—it is usually the lower lobe—and you are very much surprised. It is rather inexcusable if pneumonia is not suspected. Of course it should not be overlooked, even if not suspected. It is difficult to know what to say, if you are called in consultation, the child has been suffering probably five or six days, and it is then discovered the child has pneumonia. The family want to know why the other physician did not know it.

In cases of tubercular pneumonia there will be scant physical signs. Even after the condition has existed for several weeks, when there has been ample time for physical signs to develop, or when pathological conditions are present which should present physical signs, they are apt to be obscured by the emphysema produced. Also, you will have more cyanosis than you have in the average case.

DR. WESTNEY: I move that the Society extend a vote of thanks to Dr. Raue and Dr. Simonson for coming here, giving these papers, and taking part in this discussion. The motion was seconded and carried.

## REMEDIES IN INFANTILE PNEUMONIA.

BY

WALLACE MACGEORGE, M. D., CAMDEN.

As a prelude I wish to say some things which may render me liable to criticism, nevertheless, because I consider them timely and appropriate, I call your attention to them in the treatment of young children.

He will be most successful in the treatment of these cases who wins the confidence of his patients by gentle, kindly and considerate treatment. An infant or a little child will not simulate distress or pain but will quickly express his feelings if roughly handled. In examining them use all the senses God has given you and remember the gentle touch on the diseased lung will give you as good a key to the selection of the remedy as the cruel percussion mode sometimes practiced by the exact diagnostician.

The trained eye, the attuned ear, the skillful touch will give you a vast fund of information and will help you many times in the selection of the indicated remedy. Be kind and gentle with your little patient and he will watch for your coming and frequently come to your arms and sit in your lap while you are, unconsciously to him, going over his case.

I have very little trouble in winning the compliance of my patients except in those cases where antimonium crudum is the remedy. Even these on the second or third visit will allow me to examine them as I should. To be successful, then in treating young patients with pulmonary complaints, you must learn first of all to be gentle in your touch and kind and considerate in your manner.

Objective symptoms predominate largely in all cases of young children, and many times a single objective symptom points unerringly to the indicated remedy. Not all the remedies used in infantile pneumonia will be named for the following reasons: I do not know all of them and I have not time at this session to give indications for all I do know, so I have chosen aconite, belladonna, bryonia, ipecac, lycopodium, phosphorus, sulphur and tartar emetic.

*Aconite* is indicated in the very beginning when there is high



fever, dry skin, restlessness and an anxious countenance. Aconite has been used when these cases cough and have a loud rattling during expiration but not during inspiration. It is needed when the onset of the disease is sudden. A single dose as soon as a child has taken cold or been exposed to cold will frequently clean up the whole trouble. If given early enough, aconite will frequently cure the group of symptoms seen in cases of broncho-pneumonia or capillary bronchitis as it was called forty or fifty years ago. This was forcibly impressed upon me away back in 1875 when I had the late Professor N. M. Guernsey see a two-year-old child who had been sick a week or more with pneumonia and, as a German friend of mine used to say, "He got us better fast." Dr. Guernsey observed that the child was hot, restless, thirsty, had plenty of fever and an anxious look for one so young and he had a dry, rasping cough.

Turning to me he said, "We will give the child aconite, and all the cold water he will drink; fever is fire and we put out fire with water." Aconite was given at once and the child made a quick recovery, and needed no other medicine. In after years I was sorry that the child had not died then for he lived to bring the father down with sorrow to the grave. Twenty years after in a fit of uncontrollable rage or jealousy, he shot and killed a young woman who would not accept him as a lover and then turned the pistol on himself falling dead alongside of his victim. But the aconite was not responsible for this tragedy.

*Antimonium crudum* is useful in the old-fashioned cases called catarrhal fever or catarrh of the bronchi or capillary bronchitis, but scientifically known now as broncho-pneumonia. The mental symptoms—"The child cries as soon as you touch it or even look at it" is the keynote calling for it, and antimonium crudum has helped me so many times, that I wonder I do not have more of its administration in these cases. From my observation, the child is sore, not sore enough for arnica and does not want to be touched for fear you will hurt it, and that is why it comes harder when you do touch it, and the patient sometimes cries even if you look at it for fear you will touch it.

In such cases I sit down and talk with the mother or nurse and find out from her all she knows about the case. I keep my eyes on the child's breast, my ears open for rales and

wheezing and cough, but I do not look directly at the child's face. In a few moments the child realizes that I am not going to touch it nor take it up and stops crying, watches me and everything I do. Sometimes I find the child has been sick two or three days before the doctor was called in and has not enjoyed the home remedies which he has had to swallow. If the tongue is white coated, all the more reason for giving antimonium crudum. I have prescribed this remedy in lung troubles when this characteristic symptom was present and in every case but one with curative results. In that case the broncho-pneumonia supervened in an attack of whooping cough and the child left this vale of tears, notwithstanding the fact that I gave him what I considered the indicated remedy.

Arnica is a great favorite and has made for me innumerable friends in my many years of practice. Soreness is the characteristic symptom calling for its use. The child cries every time he coughs because his lungs are sore. Many times he will hold back the cough as long as he can and then cry before he coughs for he feels the cough coming. When the child withholds his cough or when he holds it back because it hurts him to cough, arnica is the simillimum. There will be improvement in from twelve to twenty-four hours; in a week the child may be well dismissed.

Arnica has a wonderful effect upon the heart when that organ is thumping so hard it makes the body shake, and increases the pulmonic trouble. Arnica will give permanent relief. In all the years I have been practicing, I do not remember a case to whom I had given arnica that did not get well.

Belladonna is a glorious remedy in lung troubles of children as well as of adults and it many times cures the case without the assistance of any other remedy. When the attack comes on suddenly, when there is high fever with white coated tongue, when the child is out of terms with everybody and everything; when there is hot head, red face, tingling of the facial muscles and sometimes slight strabismus—give belladonna high.

It resembles arnica in the crying after coughing with this difference—the child cries during the cough, while with arnica the crying sometimes precedes the cough and always follows the coughing spell. Belladonna has more fever and the child recovers quicker when belladonna is the remedy. The redness

of the cheeks is not circumscribed like phosphorus or sanguinaria and may extend over the whole face, scalp and neck. Sometimes belladonna has a pale face. Belladonna high works quickly and works surely. Frequently on the second visit so much improvement is manifest that I am able to give the anxious parents a great deal of comfort. I have never used this remedy lower than the thirtieth potency in pulmonic troubles and have made many hearts glad by the prompt relief this remedy has given.

*Bryonia*.—Dewey says, "Bryonia is the remedy for pneumonia; it furnishes a better pathological picture of the disease than any other, and it comes in after aconite, ferrum phos. and veratrum." But I never was very strong on pathology, and this presentation of the case does not appeal to me. In pleuro-pneumonia it is certainly useful, and if the characteristic symptoms of bryonia were present and covered the totality of the symptoms, I should use it. But, in my opinion, bryonia is not often called for in infantile pneumonia and I leave to others to draw a picture of this remedy when it should be given in lung diseases. When both lung and pleura were involved, I should certainly use bryonia and I should probably use it in the second or third potency, for I have observed quicker and more lasting results from the low potencies than the high potencies with this remedy.

*Ipecac*.—This is not a long-acting remedy, but it is a mighty quick one when indicated and oftentimes a dose or two of it will clear the way for a deeper acting remedy to get in its work. When there is phlegm rattling on chest and the child seems to be full of it, but can not raise it, or when the chest seems full of phlegm but does not yield to coughing, a single dose of ipecac high will bring almost instant relief. In incessant and violent cough with every breath in delicate children with great paleness of the face, and when the child loses its breath with the cough, turns pale in the face and stiffens—ipecac is the remedy. In cases where the mucous is streaked with blood, or when there is bright red blood after an attack of coughing, ipecac is certainly fine. Whether there is much blood, or just the faintest streak, if the effort to raise causes nausea, ipecac is the remedy and will not disappoint you. It has a wonderful effect on the peripheral extremities of the pneumogastric nerves and this is why it is so good in asthma



and in other spasmodic affections of the lungs. It is my second choice in asthma when bryonia fails to relieve.

*Lycopodium*.—The characteristic symptom for this remedy in pneumonia is "fan-like motion of the nostrils," as Dr. Cole Lippe gives it in his "Materia Medica," of "fan-like motion of the alae nasi in respiratory diseases of young people and children," as Dr. Wilson states it. There has been considerable pneumonia and bronchitis this winter and spring in our vicinity, and I have cured several cases with lycopodium when the normal symptom was present. Sometimes lycopodium cured cases without recourse to any other remedy, but in my private practice I have had to give aconite occasionally when a fresh cold was taken. Ipecac if the child felt sick at its stomach from swallowing so much of the phlegm; tartar emetic if the child's lungs were filled with mucous without the power to raise it.

Respiration with mucous rattle is one of Guernsey's key-notes, but lycopodium will be of great use long before there is rattling. Our English friend, Dr. Pope, says, "Few medicines are so valuable in pulmonary phthisis as this when persistently used. The cough, gastric irritation, exhaustion, and intermittent attacks of pleurisy are wonderfully mitigated by it." It has cough with difficult respiration and stitches in the right side of the chest. Lycopodium is a right-sided remedy, particularly in diseases of throat and lungs. Most of my cases have been in the right side and in the posterior portion of the lower lobe oftener than anywhere else. Yet I would give lycopodium if the old nasi symptom was present no matter which lung was affected.

*Phosphorus*.—Hughes says that phosphorus "is the great Mogul of lobar pneumonia," and should be given in preference to almost any other medicine in acute chest affections in young children, but my experience does not corroborate it. In hacking cough it is fine; when there is circumscribed redness of one cheek, or when the spot is nearly purple, it will often be indicated. There is soreness while coughing and the child holds the diseased lung with its hand while coughing to relieve this soreness. Bryonia has this symptom in a greater degree than phosphorus. In cough with nasty sputa, phosphorus and sanguinaria should always be considered. Sanguinaria is more often indicated when there are valvular heart lesions and also in adolescents.

Burt says, "No remedy has a more powerful and profound action and well has it shown the beauties of specific medication in pneumonic diseases, especially in the second stage, typhoid form, with grey hepatization and purulent infiltration." But my energies have been used to prevent this condition and so far I have not had to make a post mortem examination and therefore I cannot vouch for Burt. It is not the pathological condition that interests me, but the selection of the homœopathic remedy and a speedy restoration to health. I am content to cure my cases and let the other fellow make the prognosis and post mortem. In my vocabulary there is no such word as fear as long as I give the proper remedy.

When the child coughs, if it talks much, or if it coughs after laughing or from inhaling cold air, give it phosphorus.

Nash says phosphorus attacks the lower half of the right lung, but in my experience it is good when any part of the lung is affected. Nash also uses it to lock up the stage of hepatization and promote absorption or isolation. There is no remedy will make the consumptive raise quicker than phosphorus, but if continued too long, it hastens the breakdown and wearing out of the lung. Phosphorus will make the consumptive child more comfortable, and phosphorus will send him to heaven quicker than any other homœopathic remedy.

*Sambucus Nigra*.—This remedy is good in cases of suffocative cough, in crying children or in children of tubercular antecedents, and sambucus will cure these cases in the early stages, at least, as I have happily observed many times. The sambucus patient gets cross about midnight, the belladonna patient is generally cross after midnight. I wash the sambucus patient when there is dry heat while asleep and profuse sweat when awake.

My associate Doctor, N. B. Dean, promptly relieved with sambucus 200, a child who woke up with a cough and immediately began to sweat. As soon as he went to sleep, the sweat dried up and the dry heat returned. No other remedy has this symptom that I am aware of. Sambucus is useful in asthma, malaria and in coughs when the patient wakes up worse like lachesis. If the child has a tendency to sweat after the least exertion, or if it breaks out in sweat after a paroxysm of coughing, all the more reason to think of sambucus for your patient.

*Sulphur*.—When in doubt, give sulphur, the early father

said. But there are times when you can give sulphur because it is the remedy beyond the shadow of a doubt. When there is much rattling of mucous in the lungs, and the cough is worse in the morning, Guernsey says, use sulphur. When the properly indicated remedy fails you, or where there is an accumulation of mucous in the pleura or in the chest cells, sulphur will help amazingly. We do not often see these cases in children, but when I do I use this remedy and leave my troca at home. Sulphur will absorb the fluid more safely though not as speedily as an aspirator, as I have demonstrated to doubting residents more than once. Another symptom—"Children cannot bear to be washed or bathed"—comes in very often in these cases. They cry when they are washed, they cry again when they are changed, they can not bear the sight of water. They sometimes cry when you give them their medicine in water. In cases where another remedy seems to be indicated, but when the stools are very offensive and the mouth and other orifices of the body are a bright red, a dose of sulphur dry on the tongue will overcome the disagreeable odor and the other medicine do its work more certainly. "White-coated tongue with tip and border" is often seen in pulmonic cases, and points to this remedy. Where the child excoriates around the arms or in the folds of the skin, and we sometimes see this in scrofulous children when the lung trouble is clearing up—sulphur often puts the child on its feet.

*Antimonium, etc.*—Potassium tartias or tartarus stilbiatus may sound scientific, but tartar emetic suits me better. What a wonderful remedy in grave stillborn cases of pneumonia. How quickly and how beautifully it does its work! In the very beginning of life it will help, in the ending, no medicine can give more relief or make the finale more peaceful. How powerful for weal or woe! No wonder this invention of the alchemists was put under the ban and was forbidden by the French Academy because it was so dangerous and fatal in ignorant hands. Given in the potentized form it is safe and curative. Do not give it in the lower potencies, for it is dangerous to leave with ignorant people. Even the regulars as they call themselves only prescribe it in doses of one-thirtieth to one-fifteenth of a grain as an alterative and in doses of one-twelfth to one-sixth of a grain in pulmonic cases. My experience has been with the 200th and, latterly with the 30th potencies (Boericke & Tafel's preparation).



Where there is apathy and indifference to everything, when your patient shows no interest in your presence and barely answers your questions even with a monosyllable, when the heart's action is feeble and irregular, when the lungs are rattling and apparently filled with mucus, when the kidneys are laggard in their work, when the skin is cold and clammy, when the face is purplish and the eyes are lustreless, when you are afraid you have been called too late, give tartar emetic in water and repeat every three, five, or ten minutes according to the urgency of the case. As soon as you see relief slow up, but do not stop giving your remedy until all danger is past.

When there is rattling in the bronchi which can be heard as soon as you enter the room, rattling in trachea which continues until the mucous is raised and swallowed, rattling cough worse at night with suffocative spells, with sweat on the forehead, when he coughs till he vomits his food, when the cough ceases, less and less often, and cyanosis is setting in give tartar emetic and give it hopefully, for if there is any remedy under heaven that will do more for you in such cases, I have not made its acquaintance.

Hering recommends it in profuse mucous, with feeble expulsive power in bronchitis in infants and old people, also in those cases where children cough and gape alternately and seem to be in much distress. Lippe says the child wants to be carried but cries if anyone touches it.

In impending paralysis of the lungs from a giving out of the pneumogastric nerve, tartar emetic will occasionally pull the patient through as I observed in an old German seventy-four years old last March. In answer to a hurry call I found him apparently dying, his children watching for the end, but tartar emetic, thirty in water pulled him through and he has been quite comfortable ever since. Even when the paralysis is not stayed, tartar emetic relieves the dyspnoea and enables the patient to pass peacefully away, as I observed in a case I attended with Dr. S. E. Allen in 1869.

#### CLINICAL CASES SHOWING REMEDIES USED.

*Aconite*.—On January 15, 1913, at 11 A. M., J. A., sixteen months old was admitted to the children's ward of the West Jersey Homœopathic Hospital with the following history: Took cold last Monday (Jan. 13th) wash day; and he has

been growing worse since that time. Body hot to the touch, child is sleepy. On admission the child was given a warm sponge bath; temp. 105, pulse 176, respiration 60; skin hot and dry, cheeks flushed, cotton jacket applied.

At 1.20 I saw the child and advised aconite, 30 every hour, and water whenever he could take it.

*Diagnosis:* Broncho-pneumonia. By three o'clock the child perspired considerably and lay quiet most of the time. At 4 P. M., temperature 106, pulse 170, respiration 60; rolled head from side to side. At 5 P. M. seems more restless, does not take nourishment too well, pushes bottle away. At 6 P. M., large, soft, yellow stool. At 8 P. M., temperature 107, pulse 189, respiration 84, perspiring freely about head; is very restless, throws hands and feet about and tries to get up. Ice cap applied to head, hot compress to feet, after which the child became quiet and slept. Respiration labored, expelled gas from rectum. At 10 P. M., pulse 188, respiration 96. The temperature was 107 and at 8 P. M., pulse 188, respiration 84; small green and yellow stool; water given; skin feels cooler, ice cap removed. Lies with eyes partly opened, loose cough but does not cough very often, grits his teeth. At 2 A. M. hot compress renewed. At 2.10 A. M., babe straightens body and becomes rigid; clinches fists, small green and yellow stool, very restless, pupils dilated. At 2.30 unable to get pulse; oxygen now administered by Dr. David, the resident: child cyanosed, eyes glassy. Cold packs applied. At 2.55 he was gasping, at 3 A. M. he died. These copious notes are from the hospital records. It is given here to disprove the charge that we do not report our failures—only our cures. Had I seen the child in the evening I should probably have given the *veratrum viride*, but as we had a careful and skillful resident on the spot, I did not visit the hospital in the evening. The patient responded to the medicine, for there was perspiration in less than three hours after aconite was given and this is always a favorable symptom where the temperature is too high.

My impression is that there had been too much delay in coming for this child who had been allowed to go forty-eight hours before any medical aid was sought. The ice bag was ordered by the resident and is the scientific way, but I have never ordered an ice bag and never will. I do not believe in

the slow freezing, but I do heartily approve of hot applications when any local treatment is necessary.

*Lycopodium*.—On January 13, 1913, at 4 o'clock in the afternoon, P. P., a sickly, ill-nourished baby, four months old, was brought to the hospital. The history of the case showed that the child had been sick two or three days, the child's mother had to work for her living and could not give her proper care and attention. Examination showed both lungs filled with large, moist rales, expiratory effort hard and accompanied by a high pitched sound, blue facies, buttocks raw and excoriated, temperature 102, respiration 60, skin warm and dry, profuse, thick, greenish coryza, wheezes when breathing, expiration appears difficult, tongue has thick coating, vomits thick white mucous, eyes heavy in appearance, edges of eyelid red, tosses head from side to side, abdomen distended, large dark green stool with mucous in it. Specimen from nose and mouth taken for examination which we later reported to be negative. The aconite 30. At 5 P. M. expelled large amount of gas from rectum and had large greenish brown stools. At 7 P. M. respiration easier, body moist to the touch, spasm of coughing lasting three minutes. During the night had three light and dark green stools.

January 20th. Was very restless and fretful, had a hoarse, whining cry; pulse 150, full and throbbing; temperature 102, respiration 64. At 8 A. M. she was restless and fretful, tongue and roof of mouth has a yellowish white coating. Yellow discharge from right ear. At ten o'clock I saw the child with Doctor R. The facts as above revealed were given me and I looked the child over well. It was not a particularly encouraging case. The symptom most plainly observable was the fan-like motion of the *ali nasi*. This points unerringly to *lycopodium*. Turning to the resident, I asked what medicine had been given, and he said, aconite. In reply I said *lycopodium* was the remedy now and the only remedy to save us from filling out a certificate. The fan-like motion decided for me; but then the coryza with acid discharge; the tympanitic condition of the abdomen and green, offensive stools—were all covered by *lycopodium*. *Lycopodium* 30 in water is given every hour when the child was awake until Jan. 27, when it was discontinued and one whole day was spent without any medicine. On Jan. 28, 29, and 30, it had *calcarea carbonica* 30, one powder each day.



During the eleven days the case was under treatment, the temperature ranged from 103.4 on Jan. 20, to 97.4 on Jan. 30. After the second day the pulse dropped gradually from 150 to 130 and the respiration from 64 to 32 on Jan. 30. By that time the cough was gone, the coryza had ceased, the discharge from ear had stopped and the stools had gradually become of brownish color. It was visiting day, the mother saw her child was so much better and begged so hard to take it home with her, that I reluctantly consented to let the baby go, for, during the time it was in the hospital in spite of the good care our nurses gave her, she lost twelve ounces in weight. The resident tells me the child got entirely well.

*Sulphur.*—On April 19, 1913, at 10 P. M. I was asked to see a child in the children's ward with the resident, the visiting physician being out of town. It was a case of pneumonia, a girl three years old who had been sick four days and had gotten much worse during the day. The temperature was 106, pulse 150, respiration 48. The child was irritable and cried if touched or looked at. There was some rattling and she had a nasty dry skin. The child was getting antimonium crudum and its mental condition certainly called for this remedy. The temperature and pulse had both risen during the day, the stools were very offensive, the mouth and lips very red and the skin was rough and dry. I advised that a dose of sulphur be given dry on the tongue and to go on with the antimonium crudum in the morning, the child to have cold water every hour. At 10.15 P. M. the sulphur was given and soon after she went to sleep. April 20th, 3 A. M. she was restless and at 11 A. M. there was apparently a crisis, for soon after the temperature dropped to 101.4, the pulse to 120, respiration to 28. At 3 P. M. temperature 97.2, pulse 120, respiration 32. April 21st the temperature, pulse and respiration all went up, not as high as before; April 22d at eleven A. M. the temperature was normal, pulse 124, respiration 28. At 6 P. M. temperature rose to 99.4, pulse fell to 120, respiration to 26. April 25th, 11 A. M., temperature 100, pulse 112, respiration 28, and very little cough remaining. On April 26 she looked so well and begged so hard for food other than the prescribed diet which was allowed and it would have made anyone happy to see how pleased she was. One more dose of sulphur was advised and improvement continued uninterruptedly after that time until her discharge.

*Tartar Emetic.*—In the spring of 1875, I was called to see E. W., the babe of one of my families. The father was an old-fashioned man, the mother was a large, fine looking woman not ashamed to nurse and care for her children and she had several of them. The hotel was old fashioned, heated by stoves—hot in the room and cold in the hall. When a door was opened a cold draught blew in and all the conditions were favorable for colds and bronchial troubles. The babe had been ailing all night and on this Sunday afternoon got much worse. When I arrived I found the child hot with fever, rales all over her chest, stupid and drowsy, taking no notice of anything. I watched that child five minutes, heard the ominous rattling and dissolved some tartar emetic, 200, in water and tried to give her a spoonful, but she could not swallow it and I held her so it should not run out of her mouth, repeating this procedure every five minutes for one half hour. There was very little response except that the rattling was a little less.

Once I opened the mouth a little wider than before and the father turned to me, "Don't you see she is dying? Why do you torment her so? I can't stand it any longer." I turned around to the mother and said, "You sent for me to attend this child and I am going to do what I can to save her. What I do does not hurt her. Shall I continue or shall I stop?" The mother said to me, "Save the baby"; to the father she said, "Go down stairs and don't come up again until I call you." The father went down stairs and I stayed with the mother and child. In half an hour more the child breathed easier, the rattling was lessened and she went into a peaceful sleep. I ordered the medicine given every half hour the child was awake, but not to disturb her nor wake her up and I went home feeling that I had won out in the fight with Death. The child made a rapid recovery, grew up to be a beautiful woman and is to-day the wife of the Mayor of the city in which this event took place. One thing more, the father of that child was my steadfast friend, notwithstanding I was an out and out temperance man and he sold rum.

**THE REASONABLENESS OF HOMOEOPATHY.**

BY

EDWARD RUSHMORE, M. D.

IN a system which has to do so largely with practical results there would seem to be but little room for speculative inquiry. Yet when results flow from an orderly procedure, the inference is that the results are according to reason, and that the method of obtaining them is a legitimate field of speculative inquiry.

The susceptibility of the human body to medicinal influences is a fact of great importance. A modification of effect will appear, depending upon the time of duration of a medicinal impression; the earlier disturbances are generally followed by disturbances of an opposite kind. This seems to be a law of nature and to constitute the possibility of true medicinal or homœopathic cure. The effects opposite to the former effects of a disturbing agency, by some called secondary, are acknowledged to be more lasting than the primary effects, so that the power of a disturbing agent may be said to excite a reaction against itself. It is this necessary inevitable and prolonged reaction which the homœopathician avails himself of for the purpose of medicinal cure.

Allopathy, using the term in a scientific and not in a partisan sense, employs agents of which the primary effect is different from and may be opposite to that of the disease-producing cause in the patient; the result is functional alteration, often attended with sensorial relief. But the primary effect is transitory and the inevitable long lasting reaction against the disturbing agent is in the direction of an aggravation of the diseased state, and in several acute or deep-seated chronic conditions the effect is most serious. But homœopathy, using this term too in its scientific and non-partisan sense, applies always the similar irritant, that is, one that produces in the healthy, symptoms or conditions most like those of the sufferer whom it is desired to relieve. The action of the remedy is in the same line with the action of the disease, and experience shows that the dose may be large enough to produce an overwhelming aggravation of the disease. But if the dose be not too large the inevitable reaction soon follows; the drug and the disease are similar; reaction against the drug is therefore necessarily



against the disease also, and in the direction of cure and health. The longer, therefore, the reaction continues the better the health, and the patient never needs to "get over" the effect of the medicine because the effect is health.

Why should a remedy be apparently able to substitute its own control for the control of the disease-producing cause over the vital reactions? Is it not a fact that drug action is more certain and uniform than most causes of disease in the human system, thus indicating a greater susceptibility of the system to the action of drugs?

A careless homœopathy may find complacency in an early removal of symptoms which is allopathic in reality and which only obscures the case for purposes of ultimate cure. The daily increasing wealth of our literature in the beneficent results of homœopathic law affords the rational bases upon which that law is established as the true medicinal ministry of health.

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The discussion on Dr. Rushmore's paper was led by Dr. Wilson.

DR. WILSON.—I confess that in the depth of the philosophy, to which Dr. Rushmore has gone, I find it difficult to discuss this paper. I cannot add very much to the testimony of results, such as we get from a man like Dr. Rushmore, from a man who has been in practice for many years. I am sure that we younger men can at least appreciate the fact that he is so thoroughly satisfied with the true homœopathic practice that we could endeavor, at least, by deep study, by the study of cases and by the study of *materia medica*, to follow in his footsteps instead of being led on, just for the sake of results by taking the so-called easier path. I hope that some of the older men will have something further to say on Dr. Rushmore's paper.

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### THE CARE OF THE WOMAN POST-PARTUM.

BY

H. L. MAPS, M. D.

IN my study of obstetrics as a medical student I think I received the impression that the woman I attended or was about to attend was ill, and that it was my duty as a physician to be ready with my instruments and remedies to interfere as soon as I could see indication for so doing.

After a little practical experience in obstetrics I changed my mind and I feel now that a pregnant woman or a woman on labor or post-partum, other things being equal, is a normal healthy being undergoing a physiological rather than a pathological condition. While I do not mean that it is never necessary to interfere, I believe the more the case is left to nature the better for the babe and the better for the mother.

Immediately after delivery I try to keep the mother as quiet as possible, in a well ventilated room, without a binder of any sort, which I believe can do no good and may do much harm.

After awakening, all the water the patient wishes is given and for the first twenty-four hours I advise a liquid diet as that is about all the majority of women care for, and there is less chance of upsetting the stomach of any patient on an easily digested diet than one of another variety. On the second day the patient has a soft diet and after that regular diet. I make it a point to advise plenty of fruit in season, stewed prunes, rhubarb, apple sauce and foods which will act as laxatives.

The temperature and pulse are carefully watched and if these are normal the patient, outside of being kept clean, is not disturbed.

If on the second, third or fourth day there is a rise in temperature to 100 or 101°, which is a fairly common thing, and upon further examination we find a foul smelling, more or less profuse lochia, frothy or bubbling in character, what will we do? According to text-books get out a douche bag, give a vaginal douche, repeat in from 12 to 24 hours and if the temperature goes higher give an intra uterine douche. If the woman does not get septic she may recover.

Now, what is all this washing out or rather washing up done for? Simply to get rid of this sapraemic condition by washing away the lochia infected as it is by saprophytic bacteria. Is there any danger by this method? Can anyone give an absolutely sterile intra-uterine douche? If so, how can the douche tip be clean surgically after it has passed through an infected vagina? If the idea is to get rid of this lochia why not elevate the head of the bed and let it run out itself. Saproaemia is simply due to the absorption of the toxins of saprophytic bacteria imprisoned in lochia, which is pent up in the vagina until it fills the cavity and then runs over the perineum, the vagina always remaining full.

When the patient is on her back, with the head of the bed elevated, there is no collection of fluid either in the uterus or vagina, hence, no large amount of culture media favoring bacterial growth. I believe this is a safe, sane method of treatment in which we are certainly not doing anything to favor intra-uterine infection.

The only argument I have ever heard against this method is that it might produce or tend to produce prolapse of the uterus during its enlarged and heavy state. My answer to this is: how about leaving her on her back, will she not be just as liable to a retroversion or flexion? She may change to a lateral position just the same with the head of the bed up as if it were down.

When should it be done? In any case where the lochia is foul or where there is a rise in temperature to any extent.

If I have used forceps or made an unusual amount of examinations for any reason I always elevate the head of the bed as a safeguard against future trouble. I leave a standing order with the nurse to elevate the head of the bed should there be any rise in temperature above 100, or if any odor is detected other than normal. I had an interesting experience three or four months ago when a patient had quite a severe chill and shot up a temperature of 103 on the third day. The nurse on the case was a sister of the patient. After she had told me the conditions over the 'phone she asked if there was anything she could do before I got there and before I had a chance to answer, she added, "I have elevated the head of the bed." The girl was a trained nurse but she evidently lost her head as the patient had been asleep for several hours before this and had missed one or two tests with the thermometer. When I got there I found a severe lacunar tonsillitis, which cleared up in three or four days and the patient made an uneventful recovery.

While there are a few patients who do not seem to care for the strange position at first, in my experience they all like it better and many object to letting the bed down after seven or eight days, when there is no necessity for keeping it up. I believe this is a prophylactic measure against puerperal sepsis for the reason that during the first few days following delivery the amount of lochia is normally quite large and this washes the generative tract from within outward and at the same time prevents large accumulations of lochia, which is a pretty good



culture media, and as you know, it is a very difficult thing to even keep the vulva clean and absolutely impossible to sterilize the vagina.

Drawing as we do from the slums of Dundee, many patients who have been examined and treated or rather mal-treated by midwives are, when delivery is impossible, sent to the hospital. (I refer to St. Mary's, Passaic.) After version or the application of forceps these patients are placed in bed with the head elevated and very few become septic,—while many are brought in by their own doctors who have been called by midwives, delivered and put to bed in horizontal position and sepsis has developed in a large proportion of the cases—the physician claiming, of course, that the case was infected when he was called, which is undoubtedly true.

This method of treatment has been used in the New York Lying-in Hospital for some years by certain men on the staff who have watched and compared statistics with other floors where the douche bag is used. And statistics compare very favorably for elevation of the head of the bed. In my own practice practically all beds are elevated within 24 to 48 hours to some slight degree. If there be any rise of temperature or any odor to the lochia the bed is elevated higher, sometimes as high as two or three feet, on ordinary wooden blocks or boxes. This is all I do—try it—you will find that there is a profuse flow of lochia and a drop to normal temperature in from six to twelve hours.

I have seen several cases with foul lochia and temperature to 101 or 102 douched that went on to puerperal sepsis and death which I feel sure might have been saved had the bed been elevated and the infected lochia drained out rather than being washed upward.

To recapitulate and give you the essence of my paper in a few words explaining the natural difficulties:

Remember the vagina slopes downward and backward.

The uterus downward or backward and forward with the patient on her back.

Fluid will not run up hill.

The vagina is full, the uterus partly full of lochia before there is any escape of fluid over the perineum.

That this lochia is a culture media.

That bacteria are present in the vagina and that heat, moisture and darkness are also present, offering a favorable condi-

tion for infection and also for the multiplication of bacteria.

That when the head of the bed is elevated the vagina slopes downward and forward.

The uterus downward and accumulation of lochia is an impossibility and that the flow is stimulated outward and, therefore, for any germ to gain entrance to the raw uterine cavity it must overcome the resistance of the current outward as well as the force of gravity.

#### DISCUSSION.

DR. ATKINSON.—Just a word of commendation about this posture that Dr. Maps suggests. I am sorry he did not discuss more than he did, the subject of the binder. Personally, I am against the binder, absolutely. I used to use it. It is with some the routine thing, to put it on and keep it on as long as the patient wants it on. That is probably two or three months at times. It seems to me a most foolish thing to do to the patient. After delivery the ordinary position of the uterus is with fundus slightly forward. It is forward when lying on the back. And that means good drainage, and it means an ultimate return to the normal position. With your binder on, however, you fasten the uterus in the pelvis, backward against the sacrum, preventing proper drainage, preventing the return to the normal position, and you have a tendency to turn her uterus upside down, making the fundus lie in the hollow of the sacrum instead of against the pubes. It seems to me to be the most senseless proposition of anything suggested in obstetrics.

DR. MAPS.—I said that I never use the binder. I believe it can do absolutely no good. I am not positive of that, but I am positive that it may do great harm.

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#### SOME OBSERVATIONS IN THE TREATMENT OF TUBERCULAR JOINT DISEASE.

BY

ANSON H. BINGHAM, M. D.

It is not the purpose of this paper to discuss in detail the approved treatment of the tubercular joint diseases with which we are all familiar, but merely to present a few observations as the result of the clinical study of these cases, both in hospital and private work.

It is the popular idea that the treatment of tubercular joints

is merely a matter of routine, and that once a brace or support is applied, everything necessary has been done. To the contrary each case must receive individual and careful study. From the observation of over 500 cases of tubercular disease of the various joints, we are convinced that there is no affection requiring more thought, or more careful selection of methods than the tubercular joint diseases.

While the treatment of the local conditions by braces and splints is of the utmost importance, we must not lose sight of the fact that the bone lesion is a local manifestation of a constitutional disease, and the treatment of it is influenced by this fact. So the first essential in the general treatment of these cases is to put the patient under as good hygienic conditions as possible. The first requisite being pure air and plenty of it. The open air treatment of surgical tuberculosis is nowhere more beneficial than in joint disease.

A few years ago when the idea of rest was considered of primary importance, the child was put to bed and kept there for long periods, but we found that while the local condition improved, the patient soon suffered in general health. We now insist that the child be kept out of doors all day and sleep with the windows wide open at night.

The importance of fresh air in these cases is shown by the results obtained in our city hospitals. Large porches running the entire length of the buildings were fitted with awnings as a protection against the weather, and all of our joint and spinal cases were kept out of doors day and night from the beginning of warm weather until the advent of winter. The improvement in their condition both general and local was most gratifying.

During the summer time many of our hospital cases are transferred to the open air institutions such as "Sea Breeze," and invariably return to us greatly improved in health.

As regards the local treatment of these cases, it has been customary to divide it into conservative and radical, our choice of methods being influenced by the age of the patient and the joint involved.

I think orthopædists now agree that tubercular joints in childhood can usually be cured by conservative treatment often with good function. And that here the results of conservative treatment are better than those of radical.

On the other hand conservative treatment in adults is al-



ways tedious and generally unsatisfactory, and the results obtained after radical treatment are usually better than after conservative.

From personal experience we are inclined to follow the rule laid down by Ely, "That the treatment of joint tuberculosis in children is almost invariably conservative, in adults almost always radical."

The exception to this rule must be made in cases of extensive joint disease with widespread involvement, where it is necessary to operate in order to save life. Here we usually amputate instead of resecting the joint, on account of the great shortening which follows removal of the epiphysis in childhood.

The great keynote in the conservative treatment of the tubercular joints are rest and protection, and two schools have arisen, one believing in traction, the other in fixation. For the past eight years we have combined these two principles of treatment, especially in hip joint disease, and feel that this combination of fixation with extension form the ideal mechanical treatment in these cases. The pain is relieved at once and the muscular spasm rapidly lessens.

Since this method of treatment has been used the occurrence of abscess as a complication has been much less common than formerly.

The ideal method of securing rest in tubercular disease of the hip and spine is by recumbency. This we now use in all cases of emergency, and as a routine in infancy and childhood up to six years of age.

In Potts disease we depend upon the Bradford frame or the cuirass. In hip disease traction is provided by means of the weight and pulley, the foot of the bed being raised to provide counter extension. This treatment should not interfere with the proper hygienic measures, the frame or bed being carried out of doors whenever possible.

When the acute symptoms subside we are in the habit of applying one of the ambulatory supports which will permit the child to be up and about, and at the same time carry out our principles of treatment, fixation with extension.

The treatment of tubercular abscess is one on which orthopædists have always disagreed. Some surgeons advocate absolute non-interference, claiming that in the majority of cases

the fluid will absorb. Others insist that all collections of pus should be opened as soon as discovered.

It seems to us that the middle course is perhaps the safest. If a collection of fluid appears but remains quiescent and produces no symptoms, it is not disturbed. If the tension becomes marked it is relieved by aspiration, followed by pressure by means of a firm pad.

An abscess is not opened and drained except as a last resort, as it will certainly become infected sooner or later, resulting in sinuses which will take years to heal.

The Bier treatment by passive congestion, and the injection of iodoform into the joint have been given a careful trial, but we do not feel justified in reporting positive results.

The treatment of cases of tubercular joint disease by tuberculin, vaccines, etc., from which we expected so much has been very disappointing, and there is little evidence that the vaccines have played a curative role.

Two years ago we instituted a course of tuberculin in a series of twelve selected cases, extending over a period of six months, but could observe nothing positive in the way of beneficial results.

We have under observation now fourteen cases of tubercular joint disease which have been treated with a filtrate derived from the mixed infection and the tubercle bacillus, without in any way modifying the course of the disease. This treatment has now extended over a period of five months.

While the last word has not yet been spoken in this matter, we feel justified in saying that tuberculin and the vaccines have not proved their usefulness. We cannot convince ourselves that we have seen any greater improvement in bone or joint disease than we would have expected to follow careful treatment on former expectant lines.

It must not be forgotten that in many cases there is a natural and marked tendency for tubercular disease to undergo a cure, and one must be careful not to confuse this natural cure with the result of vaccine treatment.

The use of drugs in these conditions has been of little value, and we have never seen tangible evidence of the use of a drug modifying in any way the local lesion.

The hypo-phosphites and the various preparations of iron have been given at certain times with benefit, but the continu-

ous use of drugs during the years necessary to complete a cure is out of the question.

It is far better to depend upon fresh air than upon tonics and appetizers, and much more efficacious. The one thing which has been of positive value in these cases is cod liver oil, either pure or in the form of an emulsion. This has been of such marked general benefit that we are inclined to use it as a matter of routine in cases of joint tuberculosis among children.

While we believe that the treatment of joint diseases in children should be entirely conservative, we wish to make one exception to this rule in cases of Potts disease. Here we believe that the Albee operation for bone transplantation forms an ideal method of treatment.

This operation consists in splitting the spinous processes of the vertebrae, including the healthy one above and below, for a depth of three-quarters of an inch.

A prismatic shaped piece of the tibia is removed from its internal surface, including the entire thickness of the bone, its length depending upon the number of vertebrae to be bridged. The graft is then inserted between the split halves of the spinous processes, and held in that position by interrupted sutures of kangaroo tendon passed through the supra and inter-spinous ligaments.

The child is kept in a recumbent position upon a frame or fracture bed for from six to ten weeks, and then allowed to be up and about without support of any kind.

This results in a firm, solid bridge of bone which absolutely and permanently fixes the vertebrae at the seat of the disease, far more effectively than any external brace or plaster of paris jacket.

Albee reports fifty-five cases successfully treated by this method, and from the results obtained from this operation in our own cases, we feel that at last we have at our disposal a positive and effective method of treating spinal tuberculosis.

In closing we wish to make a strong plea for the early diagnosis of the tubercular joint diseases. Every child who limps or complains of a more or less persistent pain should in every case be examined for a beginning joint or spinal inflammation. A great many of these cases with which we come into contact have been treated for rheumatism, growing pains or an acute injury, and the case has progressed so far that extreme destruction of the tissues has taken place. Not infre-



quently the case has reached the stage of abscess formation before a diagnosis is made and proper treatment applied. Our success in treating these cases is in direct proportion to the stage which is present when the child is referred for treatment, for if we can begin proper treatment in the early stages, we may expect not only to shorten the course of the disease, but to provide the child with a useful limb with the minimum amount of deformity.

#### DISCUSSION.

DR. VOORHEES.—I am not prepared to open the discussion, but I want to say that I appreciate the paper very much. It was very instructive to me. I have had but one case of tubercular joint disease, of the knee. I feel that I am very incapable of speaking on the subject. I appreciate the paper very much and I want to thank Dr. Bingham for it.

DR. TAYLOR.—Dr. Bingham has called our attention to the early diagnosis of these joint lesions. I would like to ask him what are the indications upon which he bases his diagnosis of the tubercular lesion.

DR. EKINGS.—I would like Dr. Bingham to bring out in his discussion the point of which I spoke yesterday morning, that is about the specialist using homœopathic methods in the treatment of hip disease, especially,—whether the prolonged use of the homœopathic remedy is to be advised.

DR. BINGHAM.—In reply to the question as to the diagnostic signs, we are accustomed to base our early diagnosis of tubercular joint disease upon the history of the case, and not upon a physical examination. The history of the case of tubercular joint disease is liable to be very atypical. The child has a slight limp, which is the first symptom noticed, and the parent will tell you that some time ago the child sustained a fall, but appeared to be uninjured at the time, and presented no symptom. Two or three weeks afterward they noticed the appearance of this limp, accompanied by considerable pain. The great diagnostic point in this history is the length of time between the time of the injury and the appearance of the first symptom. The ordinary symptoms of tubercular joint disease can be run over quickly. In our college teaching we divide them into eight symptoms: pain, heat, swelling, pain on pressure, limited motion, muscular spasm, atrophy and deformity. Eight seem to be all the symptoms in the atypical case of tubercular disease of any joint. Another very typical symptom in the early stages is the night cry. This is explained by the fact that during the day time the muscles of the area of the disease are in a state

of tonic spasm, holding the joint quiet. This is nature's method of protecting the joint from injury. In the night time, while the child is asleep, this spasm is relaxed, and the joint no longer protected, and any little motion, such as turning in bed brings the inflamed surfaces together, and the child awakens with this typical cry.

There is one other method of treatment I forgot to mention, through an oversight. That is the injection of bismuth in the treatment of tubercular sinus. We use a mixture of subnitrate of bismuth and vaseline, one to three, and inject it at a temperature of 110 degrees. This was first used for diagnostic purposes only, and simply to find out the extent of the sinus. But X-ray pictures have shown that some of these places have healed, and the result is it is now used for its curative effect. We feel that we have seen more good results from its use than we have ever seen with iodoform, the injection of iodoform into the joint, for two reasons. In the first place we have seen two cases of undoubted iodoform poisoning, and again, we fail to see how the injection of iodoform is going to affect the joint, the fibrous adhesions, or influence the course of the disease, deeply seated in the bony structure.

DR. MAPS.—I move that a vote of thanks be extended to Dr. Bingham. (The motion is seconded and carried.)

DR. EKINGS.—We did not hear anything about the homœopathic remedy.

DR. BINGHAM.—There is very little to say. I think we are all liable to grasp at a straw. We treat according to indications, but if the case is a chronic one, I say I fail to see any results from the homœopathic prescription. We have used tuberculin, extending over a period of one, two or three months, but we do not feel justified in depending upon our prescription.

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### COMPARISONS IN ANAESTHESIA.

BY

G. HERBERT ALLEN, M. D.

LADIES AND GENTLEMEN.—When Dr. Doremus asked me to read a paper on *anaesthesia* I hesitated, and said I thought you would rather listen to a paper from a man with wider experience, but he replied that if I didn't know anything about the subject they had better get some one who does to give their anaesthetics.

I then thought I would get hold of all the literature avail-

able on anaesthesia of all forms, which as you know is very limited, and compile a regular compend. After further consideration I decided to give only my own experience with nitrous oxide, oxygen and ether, and with ether alone, thinking that although my experience has been rather short to date, it might prove more interesting and profitable, than for me to copy and relate the experiences of others which you can read for yourselves at your leisure.

One year ago last December I started with nitrous oxide and oxygen and in series of about 250 cases used it exclusively, with the addition of ether in most cases after the first 50. At first we were very enthusiastic about it, but after two deaths we began to have a little more respect and esteem for our old friend ether. One death was in a case of exophthalmic goitre seemingly wholly due to the anaesthetic; the other, however, was in a patient past 60 with a large ovarian cyst, causing a good deal of intra-abdominal pressure. The anaesthetic was all that could be desired, until the cyst was lifted quickly through the incision. The patient's pulse stopped at once, and although respiration continued for a short time, the heart never beat again. Paralysis of the respiratory centre in the medulla is the usual cause of trouble when using gas, and it seems in this case as though the sudden change in pressure on the abdominal aorta and the portal circulation, may have been the cause of death, rather than the anaesthetic.

Now a few things about nitrous oxide gas. A hypo of morphine seems almost imperative and when the gas works well there is nothing to equal it, but the danger line is so fine and ill defined, and absolute relaxation can not be secured without a certain amount of cyanosis, and an increase of arterial tension. This is especially so in abdominal cases and unless considerable ether is used in conjunction with the gas, the anaesthetic may have to be forced, more or less depending on the patient, to a dangerous stage to produce the relaxation needed for pelvic work and to close an abdominal incision.

It seems to me that its greatest field lies in work other than that on the head, face or abdomen. It has caused great advances in dentistry and pleasing reports come from the field of obstetrics, although here the cost is a considerable item.

Nitrous oxide in combination with oxygen may be used for any length of time, and seems to run more smoothly the second half than the first. The apparatus should be as simple as



possible, portable, and one of the rebreathing forms, the gas bag close to the face, both for cleanliness and to cause the patient less exertion. If rebreathing is used, pressure reducing valves and percentage gauges are absolutely useless and only an added expense for each patient is a law unto himself.

Although our percentage of vomiting is very low with the open drop method of ether administration, it was even a little lower with the nitrous oxide gas, but we had just as much peristaltic paralysis and accumulation of gas as with ether.

Shock seems to be lessened somewhat in gas anaesthesia, especially if rebreathing is used, due to lack of what Dr. Vandall Henderson terms *acapuria*. He claims that  $\text{CO}_2$  carbon dioxide serves as a stimulant to the venous tonus, and that by a conservation of a part of the  $\text{CO}_2$  shock is mitigated. Therefore, since the respirations are increased to from 40 to 60 per minute with gas, rebreathing is very essential. *Surely*, when the intestines are exposed for a long time and handled more or less, shock is increased not from the trauma, but due to the increased elimination of  $\text{CO}_2$  carbon dioxide from the capillaries in the peritoneum.

The body temperature is slightly elevated after prolonged nitrous oxide anaesthesia, but the blood pressure is also elevated often 25 to 30 points. On finishing; a little larger percentage of oxygen can be used and practically all the gas eliminated from the blood at once, thus causing a rapid return to consciousness with few after effects; and liquid or soft diet can be started almost immediately, if the surgical condition permit, but with this rapid return to consciousness, another dose of morphine is often necessary to allay the seemingly increased pain.

In septic cases; work requiring incomplete relaxation and minor operation, without the addition of ether, nitrous oxide seems to find its greatest field. It costs about  $1\frac{1}{2}$  cents per minute, or 90 cents per hour, which in hospital work is quite an item.

Now for our present method of *ether administration* in the Essex County Homœopathic Hospital. The patient is given the usual hospital preparation, and about three quarters of an hour before operating a hypo of morphine, 1-6 gr. and atropine 1-150 gr. is given. Until recently we had been using scopolamine 1-200 gr. with the morphine. This caused a mental apathy to the patient and sometimes even a loss of

memory regarding the operation, but in some cases the effect seemed too marked, and as the scopolamine had to be used in solution, thus making errors in dosage an easy matter, we are now using the atropine. This preliminary hypo makes the anaesthetizing easier, quicker, more regular and less anaesthetic is needed. All preparation is finished prior to the hypodermic and this last 45 minutes the patient is left alone to rest and is often found in a light sleep when it is time for the operation.

The anaesthetic is administered right on the operating table and by the time the surgeons are scrubbed up the patient is ready, thus avoiding delays, caused by shifting the patients after anaesthetizing or bringing them in from another room.

*Mental suggestions* seems to me one of the main features of successful induction, and it should be practised from the time the patient enters the room. If the anaesthetist is introduced to the patient as soon as he or she enters it makes it easier to gain their confidence and undivided attention.

After the patient's mouth has been examined for new creation of the dentist's art, and these are sometimes found despite negative assertions to their nurse beforehand; their hands are placed under the buttocks rather than holding or tying them, thus avoiding restraint. Next a piece of rubber tissue, moistened, is placed over the eyes, and a large Mayo mask covered with several layers of gauze is placed over nose and mouth. This is in turn wrapped with a gauze band leaving an opening two or three inches in diameter upon which the ether is dropped.

We are now ready to start our anaesthetic, and with the mask in close proximity to the face from the start (which to me is quite important) the patient is allowed a few breaths of air while they are instructed to breathe easily, just as they always do, either through the nose or mouth as they prefer. A few drops of essential oil of orange may be put on the mask to disguise the odor of the ether vapors, but I have given this up except for small children, as I found no advantage in its use, and, as Lincoln said, "You can't fool all the people all the time."

Now the *ether* is started, very slowly, drop by drop and the patient receives suggestions to relax, think of sleep and actually try to nap. Suggestions are given more or less in a monotone and near the ear. Pleasant and improved after effects are suggested, and all thoughts of fear are banished. They are told

their limbs will feel heavy and numb, and that sleep will come over them naturally. Peaceful, quiet sleep, without fear is the predominant suggestion and I believe it helps a lot. Any excitement at all is rare. If any choking sensation is present, as sometimes happens at first, they are instructed to blow the ether away; and no more ether is used *after* complete unconsciousness has taken place, than would *irritate earlier* in induction. All this time the mask is kept close to the face and the dropping *always continuous*, is gradually increased in rate, especially as soon as flushing of the face and neck appear. If there is any attempt at motion, especially after primary anaesthesia has taken place, the tone of the voice is changed and usually has the desired effect. Excitement, returning to consciousness seems to vary directly as while being anaesthetized; so that a quiet induction favors a smoother return to consciousness. Smooth, even, continuous dropping will favor induction, and all forcing of ether should be avoided. Better use a little chloroform if quick relaxation is needed, rather than forcing the ether. I have had no experience with heated vapors, but using a large Mayo mask wrapped with gauze favors a vapor thoroughly saturated with moisture and this vapor is warmer than in a small mask. In this way evaporation and absorption are favored.

Starting the incision as soon as possible, seems to favor a quicker relaxation by stimulating the respiration.

Primary etherization in dental extraction works admirably, especially if a little chloroform is added. The chloroform prolongs the effect and in the aged keeps down the blood pressure which rises a little in the primary stage.

Now, a few words regarding emergencies. If the tongue falls back, sometimes turning the head way to the side will help, as well as letting any accumulation of saliva gravitate out. Also keeping the head absolutely flat on the table will prevent many troubles. When holding up the jaw it is not enough to press up on the tip of the chin as so many do, but to actually hold the mandible up from behind its angles. In elderly people without teeth, where the respiration seems embarrassed, a small roll of rubber bandage in one corner of the mouth to normally separate the jaws will usually obviate all trouble. In very anaemic cases a slight Trendelenburg or even bandaging one or more of the extremities will concentrate more blood in the medulla. Having a warm, dry operating table, and careful pro-



tection of the intestines with as little exposure as possible favors the anaesthetic.

Surely our nausea is less than with the closed method of ether administration, and although I favor a closed or re-breathing method of nitrous oxide, results thus far compel me to favor the open drop method of etherization, which with a large mask partially covered is more or less a form of rebreathing, but with fresh air and ether continually, and thus far this seems to me to be the most practical for the general run of major cases.

#### DISCUSSION.

DR. J. W. HASSLER.—I enjoyed Dr. Allen's paper very much indeed. I agree with him in a great many things he said, but I didn't agree with the open method of anaesthesia. I do not believe that the open method of anaesthesia even though used in some of the best clinics in this country, in comparison with the closed method, can give the results. As regards nitrous oxide, and oxygen, I believe it has a limited place, a limited sphere. I am very much opposed to anybody using chloroform at any time in any case unless it is absolutely necessary to use it. I doubt if it is ever absolutely necessary to use it except in alcoholic cases, because if you have started your anaesthetic, you have just made your choice of an anaesthetic and you have already eliminated arterial pulmonary and venal conditions; so, if you once started with ether, made it your choice, there is no necessity of adding chloroform, unless it is a case of alcoholism. I enjoyed this paper. It is a valuable paper. I have enjoyed it although I have not altogether agreed with it. But anaesthetism is a case of personal equation. It is a case of what I have found out to be best for myself; and what Dr. Allen has found out to be best for himself may be different from what I have found out to be best for myself.

DR. CONDUCT.—For two years I served in India and have been associated with English physicians. I have known nothing but chloroform and we have had very great success with it. The secret of its use has always been to allow plenty of air, with all the windows open. We must allow plenty of air with chloroform. We know there are no better physicians in the world than the Scotch, and they certainly do some wonderful work with chloroform; but I am very glad indeed to find that you are doing such beautiful work with ether.

DR. KRICHBAUM.—The mental attitude of the patient before going under the anaesthetic is important. The better the patient's mental attitude the less the shock will be. I do not know that I should go to the length of using a hypodermic injection of morphine, but I would try as much as possible to get the patient into the proper mental attitude. I do not take much stock in this preparation of starving for twenty-four hours, high and low enemas, and other things. I do not think they are necessary. I would rather take a patient off the street and operate on him than all of that and I would expect to get better results.

DR. BUCHANAN.—I did not hear all of Dr. Allen's paper. I did hear all of Dr. Hassler's discussion. I am not entirely agreed with Dr. Hassler, apparently. I do not see how anybody in the face of the pathological findings can advocate chloroform for any case unless it is absolutely and positively counter-antagonistic to the use of ether. If chloroform be the anaesthetic used, it should be given by the vapor method, which allows for a free supply of air, and should be given preferably by the chloroform and oxygen combination. The chloroform and oxygen combination has shown less of the acute yellow atrophy than chloroform and air. I think the reason why chloroform is used particularly in India is the condition of the climate there, as it is on the average of a much higher degree of temperature. In warm countries we have to give so much ether that a great deal of refrigeration takes place.

As to the open method of ether, in view of Henderson's now thoroughly established ideas, I think that the closed method, whereby carbon dioxide is preserved to the body, is much more beneficial than the open method with all of its refrigeration.

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### HIGH FREQUENCY ELECTRICITY AS A MEANS OF CONTROLLING HIGH BLOOD PRESSURE.

BY

ALFRED W. WESTNEY, M. D., ATLANTIC CITY, N. J.

FROM among the patients going through my office practice my especial attention has been directed to a class of earnest, hardworking men who are shortening their days by the modern high pressure, high steam American method of doing everything quickly under as much strain as possible.

In the last five years I have felt it my duty to talk to these men and have tried to show them the error of their ways.

And with the hope that you, too, may especially notice this class, I have ventured to write a paper from the standpoint of a general practitioner, to bring again to your notice a few things which we all know.

I had a patient in Atlantic City. He was on the board of one of the biggest insurance companies in New York. He considered only risks of over one hundred thousand dollars. He told me he considered the instrument for taking blood pressure one of the greatest boons to the practice of medicine since the clinical thermometer. The purpose of this paper is more to bring out the scope of the high frequency current than to enter into the technique of its use.

There are three factors on which blood pressure depends:

- (1) The energy of the heart.
- (2) The resistance in the arteries.
- (3) The total volume of blood.

Blood pressure following acceleration of pulse will depend upon the reciprocal relation between the increase of pulse rate and the decrease of pulse volume.

With a constant heart energy increased, arterial tension means increased pressure, and the reverse is also true.

Increased volume and decreased volume *may* not influence pressure: but having a constant heart energy we would expect it to be influenced.

In a normal case, blood pressure is kept in the narrower limits by transfusion of fluid from the veins, dilation of the vessels especially of abdominal viscera, increased secretory acidity of glands, etc. High blood pressure of itself would not of necessity be a serious thing if it were not for the attending condition of the blood vessels and the heart. Arteriosclerosis does not of necessity mean calcified arteries; there are grades or degrees of this pathological condition of which the calcification is the final process. Arteriosclerosis is often caused by the acute infections, intoxications, alcohol, tobacco and lead, and also by those conditions that keep up high blood tension and the wear and tear of life. Which comes first—the high blood pressure or the arteriosclerosis? Authorities differ, but this we know—the great majority of our high blood pressure patients are good feeders. They eat too much and exercise too little, or, as some author has put it, “food in excess of work and excretion—damage from accumulation of waste, and the disproportion between the intake, work done and the output.”



The uric acid irritation of some authors—Metchinkoff with his colonic putrefaction and fermentation and irritation from absorbed toxic products. Francis Hare with his hyperpyrexemia, in which he claims overeating distends constantly the blood vessels, and secondly in the process of primary and secondary, metabolism substances may be formed which are directly toxic. We, general practitioners, know they are right. We see our patient of this class trying to make two dollars where one has been made before; eating with one hand and selling goods with the other; never relaxed. Then the intestinal indigestion; then the hardening of the arteries and the high blood pressure, perhaps a little hypertrophy of the heart or slight dilation.

Let us study for a minute the pathological changes in the arteries due to this wear and tear, etc. Thoma says the primary lesion is in the media as either an hypertrophy or a degeneration.

Then the intima, the endothelial lining of the blood vessel undergoes a change, hyperplastic in character, to compensate for the condition of the media or middle coat in order to strengthen this weakness and to restore the original lumen of the vessel. The hyperplasia of the intima may now undergo hyaline fatty or calcareous degeneration. Later, the muscle cells of the arteries may degenerate or the yellow elastic fibres and hypertrophy of the outer coat; then, given this sixty horsepower man, using too much fuel with too little relaxation and physical exercise, with arteries in this condition and a blood pressure much above the normal,—what expression will he give to his physician that will lead him to diagnose this condition?

I treated a man for tinnitus for a month by painting his nose and throat, etc., thinking the noises were due to a catarrhal Eustachian tube trouble. When I finally thought of his blood pressure my "tycos" would not measure it. It was higher than the scale.

Vertigo is common and annoying; numbness or tingling of an arm or leg or both, trembling on walking, neurasthenia, great irritability, monoplegias and aphasia, angina pectoris, cramps of the muscles, especially of the legs.

Cardiac attacks and renal changes. What is the treatment for this condition? I will repeat that this is the excuse I have for inflicting this paper on you. Learn to know these men who

are steering in this direction, warn them of danger ahead, to relax. They are bright, brainy, ambitious men, full of go. Tell them the story of high pressure blood vessels, arteriosclerosis, heart, kidney, stroke and hemiplegia. Explain your blood pressure apparatus to them. That is something they appreciate either because of their experience with over-inflated tires or of Steamboat Bill's awful fate on the Mississippi with a picaninny sitting on the safety valve.

*Exercise*—moderate in character; insist on two or three afternoons weekly at the Country Club on the golf course. I believe that golf alone, three afternoons a week, would add from five to ten years of life to this type of man, but you must get them there before too much damage has been done to the arteries or the heart.

*Restricted Diet*.—No alcohol, tobacco in moderation, butter milk, sour milk. The proteids should be markedly reduced namely, meat, fish, meat soups, gravy, eggs, cheese, milk and nuts and the vegetable meats or proteids, peas and beans; salines to keep the colon free and clean, baths, occasional kidney flushing.

Believing then that our high tension patient with arteriosclerosis already present or impending is primarily a toxic one probably of proteid origin and having tried by diet, exercise and rest and relaxation, colonic flushing, baths, etc., to get at the real cause of this affection, how can we now relieve the distressing symptoms which may persist? And have we any means other than the above of preventing or remedying the arterial changes which are or which soon will be present, the hyperplasia of the media, the fatty or hyaline degeneration or the slight necrosis? These conditions soon diminish arterial elasticity with increased resistance to the flow of the blood and probably also cause a lessening of the sucking in action of the capillaries. This, of course, throws more work on the heart, consequently, early in these cases we will find accentuation of the second sound of the heart. I will repeat that our object is to get these cases early when their symptoms are still functional, before the pathological conditions in the arteries change these cases to organic ones.

Can we control this hypertension and probably retard or heal the first changes in the arteries?

As for medicinal treatment, I always use aurum, sometimes arsenic and aconite. The latter for the numbness and tingling

which sometimes follows the so-called crisis or arterial spasms of affected vessels, passing near fibers from the centers at the cortex.

Belladonna and glonoin homœopathically, after acute cases. I have given up the use of amyl nitrite, tetronitrol, potassium iodide, nitroglycerin and sodium nitrate,—depressor drugs whose action is only transitory. Occasionally bromides in those cases of nervous origin from vaso-motor centers have proved of benefit.

Digitalis, at times by stimulating the heart, will reduce blood pressure in those cases due to cardiac enfeeblement. In this case you may be sure that vaso-constriction was compensatory to a failing heart and the physician's aim should be to strengthen the heart and the blood pressure will fall of its own accord.

So, too, in renal cases, the blood pressure may be compensatory, but these are not under consideration to-day. We are considering principally the toxic functional cases which we hope to find early before the pathological changes have taken place. The best results have been achieved by me, however, by high frequency electricity. By this means I have frequently had 250 m.m. reduced to one hundred and eighty m.m.; relieved the vertigo, tinnitus, the numbness and tingling.

I remember one woman who had frequent hemorrhages into the conjunctiva and epistaxis whose blood pressure was 240 m.m., who is comfortable and without symptoms with one treatment weekly.

It may be only a coincidence, but in the last seven years that I have been using high frequency for high blood pressure, I have not had a case of apoplexy. But I am on the lookout for these cases. I feel it my duty to warn them to beware of the strain of business. Relax, exercise and do not overeat. A man is as old as his arteries. Old age is only sclerosis so do not get prematurely old.

We lay up stores for our old age; we try, as Kim says in one of Kipling's works, to lay up virtue for consideration in the hereafter. Try to teach your real, brainy, ambitious men to lay up arterial strength for the last twenty-five years of the three score and ten.

#### DISCUSSION.

DR. BRYAN: I would like to ask the writer what his *modus operandi* is for after treatment.



DR. WESTNEY: I have a coil made by the Boston Electro-Radiation people, on the pattern of the Ariax, a ten-inch coil, and use a back frame consisting of twelve tubes.

I give treatment of ten or fifteen or twenty minutes' duration, according to my patient. I have some patients with a pressure of one hundred and ninety or two hundred, whom it will take twenty minutes to reduce ten or fifteen m.m. Other cases I can reduce more rapidly. I had one case not long ago, who was constantly taken with numbness and tingling in the right side, seemingly an arterial spasm. For two or three weeks I treated her until I brought her blood pressure from 185 to 165. The frequency of the treatment, I think, largely depends upon the class of patient you are treating. I do not get much result in kidney cases. I do not think it makes much difference what the *modus operandi* is as long as you watch the blood pressure. But don't think, simply because you have the high frequency apparatus, all you have to do is to give high frequency. I thoroughly believe in carefully finding out in each case whether high frequency is indicated, what the patient is doing, insisting upon exercise most particularly, and anything that will help the patient generally, and using high frequency just as an adjunct.

DR. PERKINS: I have had the same experience Dr. Westney spoke of with reference to those patients, past middle life, with blood pressure of 175 to 200, with my high frequency current. In fact, I have come to feel that it is the only thing, along with practical dietary treatment, rest and exercise, that can be of any great benefit. In cases of arteriosclerosis, vertigo, spasms in the limbs, it has been very helpful, reducing the blood pressure from ten to fifteen m.m. In old persons, no matter what is the matter with them, it seems to help them, help the circulation, help the action of the heart, give them new vitality, give them energy they don't get in any other way. Things seem to get going again.

In regard to the Doctor's advice, I see elderly men of business working at high tension; very often these men come to your office and say they never felt better in their lives. The next thing, you hear of their dropping in the office. That is the type of men that should take advice from their physician. And is the type of men that can be helped with high frequency. In regard to playing golf, I think that is a most excellent way. I tell these elderly people to find a game that is alternate exercise and relaxation. I don't know of any game better for the purpose than golf.

DR. ADAMS: I have been using my high frequency with a great deal of enthusiasm for eight or nine years. The appar-

atus I use the Wappler apparatus. I find it an instrument of great efficiency, and I have looked over the market pretty thoroughly. I am now using my third apparatus. At the present time I use a step-up transformer. It is an interruptless apparatus, remarkably simple and efficient. It is capable of giving twelve or fourteen hundred milli-amperes of current. I have not found any improvement on an auto-condensation chair which I have fixed for myself. It was a Morris reading chair, the back and seat of which I have covered with insulated metal plates, and simply remove the ordinary heavy leather cushions of the chair when I give treatment. I do not use the hand electrodes. The skin of the hand at best is almost impervious to electricity from a high pressure current. But I use a lead plate electrode applied to the neck. I use a plate which I have made myself, about eight by ten inches, ovoid, and I sometimes supplement that with a coil right around the neck, when I want to give a pretty high amperage without the patient having any sense of the current. I give as high as 700 without the patient feeling anything more than a moderate sensation of warmth. I have had a good many cases in the last eight or nine years.

A year ago last January a patient who holds a position of a good deal of responsibility in the New York Central Railway, and now about seventy-six years old, came to see me. He had been my patient for twenty-eight years, but I had not seen him for a considerable length of time. He complained of a series of symptoms that were rather characteristic, dull headache, vertigo, tenderness, quite complete left side numbness, tingling pain. Because the case was a very important one to me and I felt a great deal of interest in it, I referred him to a doctor in New York. At the same time I began with my high frequency. I gave him the treatment twice a week in February, and from then on to July. Before I sailed in July his pressure had fallen to 160, from 180. He has been kept down around 140 to 160 ever since. He is still under treatment. His life is worth a great deal to him.

In regard to urea elimination, I have seen it double in some susceptible cases, even after twenty minutes' auto-condensation treatment. I have found the urea content of a specimen of urine, when the patient first came to the office, by the hypochlorite method, and again one hour and a half later, and found it two and three times as high as before the treatment. This increased urea output will continue—what is more important—over a period of twenty-four to forty-eight hours.

DR. C. H. CHURCH: Perhaps it would be instructive to give a little report of the experience of Dr. Monroe. After his

death I had charge of his institution for several months, as some of you know. He was very enthusiastic over the use of the baking treatment, the oven treatment, keeping ice cloths on the head. For a long while he kept a record of the blood pressure, taking it just before the patient took the treatment, and an hour after the treatment; and shortly before his death I induced him to take it during treatment, by having the patient have one arm out. His experience over a long line of cases was that the oven, as he used it, would generally bring the blood pressure down about fifteen to twenty points, between the time the patient was put in the oven and one hour and a half after being taken out. And the few times he took the blood pressure while the patient was in the oven, it was raised about ten points, but inasmuch as he kept ice cloths on the head it was to a certain extent relieved, and danger from apoplexy lessened. In something like eight thousand cases he never saw increased pressure. Another good point—take, for instance, a person with pressure of say 200, it would reduce it to 180 or 185, and several days after it would be 190 to 192, in other words, a net reduction of seven to ten points. In that way he could work it down to a comfortable point and it would stay there for a long time.

DR. WESTNEY: There has been such perfect uniformity of opinion with regard to high frequency that I do not think there is anything further to say, except that I want to call the attention of the men present once more to that class of men who have a tendency to “drive,” and to ask them to try to get them to hold up, see that they get exercise and relaxation, and if that does not reduce the blood pressure, then use your high frequency.

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### EYE-STRAIN.

BY

L. E. HETRICK, M. D., NEWARK, N. J.

IN choosing “Eye-strain” as the subject of my paper, I realize the impossibility of covering the subject in the time allowed, and shall therefore only attempt to bring the subject before you in a general way, hoping that much that has been omitted may be brought out in the general discussion of the paper.

It will perhaps be advisable to consider, first the essentials of normal vision:

In the first place we must have two normal eyes, they must



be normal from an anatomical as well as physiological standpoint. There must be no disease of either the focusing or the receiving apparatus; the media must be perfectly transparent; the refraction must be normal; the retina, optic nerve and the brain centers must be normal. Both eyes must look at the same spot at the same time; in other words, fusion must be normal, and to have normal fusion we must have normal muscle balance; in other words, all of the extrinsic ocular muscles must equal the opposing muscles. Any variation in any one or more of these requisites will produce more or less eye-strain, varying with the individual.

The symptoms of eye-strain vary, therefore, according to the variety of eye-strain, and when we realize the requisites of normal vision, it is very easy to imagine the varied symptoms possible as a result of any deviation from the normal.

By "eye-strain" we mean any symptom or group of symptoms caused by waste of nervous energy due to efforts on the part of the organism to overcome some form of ocular asthenopia.

In eye-strain the individual's susceptibility must be taken into consideration in the same way as in any other strain. Certain persons will have ocular defects of high degree and very slight reflex symptoms, and other persons will have slight ocular defects and reflex symptoms apparently all out of proportion to the optical error.

In a general way the symptoms of eye-strain can be divided into two classes: those which are directly referable to the use of the eyes, or which are aggravated and brought on by the use of the eye, and another class, that of remote reflex symptoms which apparently have no connection whatever with the eyes.

In near-sighted persons, or in cases of myopia, the distance vision is more or less indistinct, varying with the degree of myopia. In far-sighted patients the strain is at the near point.

In myopia the eyeball is relatively too long for the focal power of the lens.

In hyperopia the reverse is true.

In astigmatism there is a difference in curvature of the cornea or lens in two diameters, the eyes may be myopic in one and hyperopic in the other. These have mixed astigmatism.

Hyperopia is divided into manifest, latent and absolute. Many cases are latent and upon being superficially tested by the school physicians or others, read the normal line on the

test chart, and are said to be normal when they are not. Weak plus lenses should be tried and if the case reads the same line as well with a given plus lens as without it, he is positively not myopic and is hyperopic at least the measure of the lens used.

Both near and far-sighted patients may have muscular deficiency in addition to their refractive error; we may have muscle deficiency or asthenopia without any, or at least with very slight, refractive error.

The symptoms of eye-strain in the first class mentioned above, are difficulty in seeing well, either at the near or far point, according to whether the case is far-sighted or near-sighted. Near-sighted children complain in school of not being able to see the blackboard well; there is more or less pain in and around the eyeball, headache, either frontal or occipital, worse when reading or using the eyes. There may be dizziness, nausea or vomiting, the headache may come on directly after the use of the eyes, or they may be periodical, coming on once or twice a week and seeming to be the climax of an accumulated strain. There may be train-sickness. Seasickness is frequently a symptom of eye-strain. The patient will complain of losing the line while reading; the type will blur, will be clear one minute and blurred the next; the eyes will smart and burn and become red. Blepharitis marginalis, chalazia, sties, etc., may all be symptoms of eye-strain.

There is a class of symptoms also which have more or less significance in the way of pointing out muscular errors; there will be confusion, no localized head pain, or pain may be referred to the back of the neck. To the question, "In what part of the head is the disturbance?" the patient will reply, "Oh, I don't know; all over." There is an inability to fix one's mind on study or reading, this is a frequent complaint of muscular cases. It is difficult to fix on an object or even in conversation to look one in the eye; vertigo, drowsiness after reading but a short time. This class of symptoms point probably to muscular defects.

Then comes the second class or remote symptoms. These are of a neurasthenic character. There is loss of appetite, dyspepsia, sleeplessness or constant sleepiness, nervousness or fidgetiness; the patient cannot sit still while reading any length of time; prolonged reading makes them cross, irritable; in fact the whole line of neurasthenic symptoms, when no other cause can be found, eye-strain should be suspected.

Perhaps if I cite one or two short cases it may serve to throw a little light on this subject.

CASE 1.—Miss R. came to me on January 13, 1913, complaining of headaches in occipital region and nose bleed; eyes get sore, smart, nausea. After a day of using the eyes completely prostrated the next day. On examination I found this case to have a vision of 20-20th in both eyes, but the patient accepts a plus .25 cylinder axis 180. She has an exophoria in the distance of one degree and an exophoria in accommodation of three degrees; there is no hyperphoria.

Scopolamine was prescribed and under the mydriatic, patient accepted a plus .25 cylinder, axis 30 in right eye, and a plus .50 cylinder, axis 150 in the left eye. On the third and final test the above cylinders were again accepted and on testing the muscles with the correction made, they were found to balance perfectly. These glasses were ordered for near work only, with the result that all headaches, nausea, etc., had been relieved.

CASE 2.—Miss B. O. came to me on November 22, 1912, she was referred to me by Dr. V., complaining of headaches over and around the eyes extending to the nose, occasionally to the occiput; these headaches would last two or three days at a time. The patient was wearing a plus 1 sphere in both eyes. Upon examination the vision was 20-20ths in both eyes, patient accepting the plus .75 sphere, there was an exophoria in distance of two degrees. Scopolamine was prescribed and under scopolamine the patient accepted a plus 1 sphere combined with a plus .25 cylinder, axis 90 in both eyes. On the final test a plus 50 sphere and a plus .25 cylinder, axis 90 in the right eye and a plus 75 sphere with a plus .25 cylinder, axis 90 in the left eye, giving 20-20th. The muscles balanced in the distance. In accommodation there is a tendency to an exophoria only about one half degree. She was last seen on February 3, 1913, at which time she reported complete relief from all her symptoms, never felt better in her life.

CASE 3.—On October 25, 1912, Dr. L. E. G., dentist, complained of blurring of vision while working on his patients. Impossible to work on a case any length of time, he must stop and rest his eyes frequently; there were no headaches, no other symptoms except fidgetiness, some slight blepharitis, some lachrymation when looking steadily at an object, vision 20-30th, difficult, is wearing plus 75 sphere combined with a plus



.50 cylinder, axis 90 with a prism two degrees base out in the right eye; plus 25 sphere and plus .25 cylinder, axis 90 with a two degree prism base out in the left eye. With a preliminary test I get plus .50 cylinder, axis 90 equals 20-20th in the right eye; plus .50 cylinder, axis 120 equals 20-20ths in the left eye. Scopolamine was prescribed and the following result obtained: plus 50 sphere combined with .75 cylinder, axis 75 equals 20-20th in the right eye; plus 50 sphere with a plus .75 cylinder, axis 105 equals 20-20th in the left eye. With the final test the patient accepts the cylinders only. The muscles at this time show an esophoria of seven degrees.

The patient was told to wear the glasses constantly and report in a month. He did so and the report was very gratifying. He has been able to do work with comfort, the muscle unbalance has decreased from an esophoria of seven degrees to an esophoria of four degrees and up to date has had no headaches.

These serve to illustrate first class of cases, those with the symptoms referable to use of eyes.

CASE 4.—Charles T., age 46, consulted me November 2, 1912. Complained of occipital headaches almost constantly, has of late been unable to attend to business, nervous, irritable, tendency to melancholy, periods of depression; came to me because a friend of his similarly affected had been relieved by glasses.

Upon examination I found a hyperopic astigmatism and a presbyopia of one and a half dioptries. Glasses were ordered with complete relief of all the above symptoms, together with a constipation from which he was suffering.

CASE 5.—Miss M. M., age 23, referred by Dr. S. Case of melancholia with tendency to suicide; history of having worn glasses as a child but not for several years. Had had a convergent strabismus. Eyes now straight. Case refused to talk, would not answer questions. Weighed 105 pounds and failing. Vision right eye 15-20th; vision left eye 15-20th. Gave scopolamine. Under the mydriatic, by retinoscopy I obtained the following: Right eye plus 1.00 sphere combined with a plus .25 cylinder, axis 75. Left eye plus 2.00 sphere combined with a plus 1.00 cylinder, axis 75. These were prescribed. Case reported in person one month later, came into the office in smiles. She was seen by me a year later and says she has been perfectly well. Now weighs 135 pounds.

These will serve to illustrate the second class of cases mentioned.

You will see that the effects of eye-strain, or nerve waste caused by ocular defects, are very far-reaching. Nervous cases with no definite symptoms, and which do not react to apparently indicated treatment, should be questioned closely to see whether or not use of the eyes aggravate conditions or if certain symptoms follow use of the eyes.

The first class of symptoms mentioned point quite clearly to the eye as a cause. The second class less clearly but in many instances, upon close questioning, you can get a statement that using the eyes makes them feel worse. Frequently you will have a case who does not care to read, or use the eyes. In such cases suspect eye-strain. Also, children who are backward in school should have their eyes tested.

#### DISCUSSION.

DR. C. C. STRAUGHN: Dr. Hetrick has called your attention to the reflex symptoms of eye-strain, and I would like to especially emphasize that phase of it. They are so remote in many instances that it almost requires a stretch of the imagination to believe there is any possible connection, and yet in all probability all of you have seen functional conditions clear up after a proper correction of the refractive or muscular fault, that you had not associated with the eye at all. It can usually be accounted for by the relief of a drain on the nervous system that allows nature to supply the organ with nervous energy sufficient for its proper function. As a case in point, Miss R., a dressmaker, age 32, came for glasses, she related the ordinary asthenopic symptoms and was supplied with compound hyperopic glasses. She mentioned no functional symptoms other than those of the eyes. Meeting her some months later she spoke of the improvement in her general health and among other things, that while she had not menstruated for a year and a half previous to being fitted with glasses, she had been regular since. Her family physician had treated her for amenorrhoea but had finally told her she had passed the climacteric. This is merely an illustration, but every oculist can relate many instances of functional conditions that have been relieved by careful adjustment of the eye fault. A few months ago, a little girl, three years old, was referred to me for strabismus. It had developed suddenly about ten days previous. While in conversation with the mother, the child suddenly

started vomiting. Upon questioning the mother, she stated that the child had always been subject to these attacks at variable intervals and apparently without cause. She had always considered them bilious attacks, as she would be all right the following day. Upon retinoscopic examination a few days later I found a half dioptre of astigmatism in each eye, which was corrected. Several months have elapsed, the strabismus has disappeared and she has no more bilious attacks. These cases are important, not only for the reason that the strabismus is usually corrected by the proper glasses, but because it very often means the difference between going through life with normal binocular, instead of monocular vision. When you consider that the hyperope or far-sighted person, and these form 75 per cent. of refractive errors, is compelled to use his accommodation to properly focus all objects, irrespective of their distance, and to use a much greater muscular effort at the near point, you can appreciate that these eyes are never passive. Such an eye is always straining more or less intensely to bring a clear image upon the retina. There is not a waking moment that this eye is not requiring more than its normal amount of nerve energy, if it is also astigmatic, and two-thirds of all hyperopes are, the drain is intensified. Is it strange that it leads to functional derangements, neurasthenia and insanity? In closing I wish to quote from Ranney, who has made a special study of the eyes in their relation to the nervous system: "Eye-strain arises chiefly from defects in the refraction of the eye and an imperfect equilibrium in the muscles which move the eyes. These conditions when present tend to cause an excessive expenditure of nerve force by the individual in direct proportion to the amount of the defect to be overcome. Excessive expenditure of nerve force upon any one organ is commonly made at the expense of some other organ, or, if not, is paid out of the 'reserve' amount of nerve capital possessed by the individual. The extent of the drafts thus made upon the 'reserve' capital and the amount of 'reserve' capital are the two factors which can alone determine in any individual case how long this state of things can last without causing a 'nervous bankruptcy.' A condition of exhausted nervous vitality is sure to impair the general health in many ways, and to render the individual more liable to disease than when in full vigor. Many of the constitutional diseases which ultimately imperil the lives of their victims are indirectly the result of the low nervous vitality, 'a state which is frequently the result of eye-strain.' The so-called 'inherited predisposition' to certain diseases is unquestionably based in many cases upon some anomaly of the visual apparatus."



**THE MOSQUITO.**

BY

THOMAS HEADLEE, M. D.

Entomologist of the State of New Jersey.

"I AM glad to have the opportunity of addressing you, primarily because I am interested in the subject, which is of prime importance, I believe, to every Jerseyman; and also because I believe that you represent the best elements in New Jersey, and I am anxious to get in touch with you, and to have your co-operation in working out this, one of the serious problems of New Jersey. The name of the grasshopper is not half so intimately connected with Kansas as that of the mosquito with New Jersey. Go where you will and mention the fact that you are from New Jersey, and if your auditor be sufficiently impolite he is likely to ask you concerning the New Jersey mosquito. It is a significant fact that the cartoons of President Wilson almost invariably at the beginning of the campaign assumed the form of the mosquito. It certainly shows the extent to which the name of New Jersey is connected with the mosquito. There are other parts of the earth where mosquitos are as bad as in New Jersey. Why New Jersey should have been given this odium I am unable to say. In fact, I could not see any particular reason for it until last fall, when in the course of my inspection of the marshes of Barnegat, I found mosquitos thicker than I had ever seen them anywhere. They rose from the salt marsh grass like a swarm of bees and surrounded my head so that I did not dare to speak for fear that I should get my mouth filled with them. I scarcely dared to breathe. I had to take out my handkerchief and drive them away from my eyes. I had frequently heard Dr. Smith say that no one realizes the nature of the Jersey mosquito until he meets him on his native heath, and until that time I did not realize what the statement actually meant. Suffice it to say, however, that the name of New Jersey, justly or unjustly, is connected with the mosquito. The problem is how to disconnect it, how to go about the business of freeing New Jersey from this mosquito incubus. And I shall try to show to-night, to some extent at least, how great an incubus it has proven to be, and something about the methods that may be used in ridding the State of it.

This is an illustration of the way in which millions of dollars are expended. (Slide of a hotel.) This is a hotel near Hopatcong, which was built at considerable expenditure of money and which was expected to yield a revenue. It failed to yield a revenue because the mosquitos were so abundant that the guests would not stay. The result that you see here is typical of a great many instances along the New Jersey coast. There have been millions of dollars of investment lost through such land as this (showing undrained marsh land). Another way in which the New Jersey coast has lost through the condition of its salt marshes lies in the fact that the grass that you see there, which is characteristic of the water-logged salt marsh, is not salable, is worth nothing, it simply cumpers the earth; yet if you take the same water-logged marsh and trench it, you will find that the grass yield will change, that the coarse grasses lose their place, and give way to the finer salt marsh grass, which makes an excellent hay, worth eight dollars a ton. Here is a salt marsh (showing another picture) which formerly grew those reedy grasses, now salt marsh hay worth twenty-four dollars, gross yield, as the result of drainage. Here is the same area with the hay piled up in stack.

"This is a blood slide (indicating), showing the red corpuscles; here is one in which the malarial parasite has not yet effected an entrance; here it is on its way into the corpuscle; here, well inside the corpuscle; here, it has filled practically the entire substance of the corpuscle, consumed it, and ready to swim out and attack a new corpuscle. In the stage when it is making its attack upon the new and untouched corpuscles, we have the reaction characteristic of the disease, the chill.

"This represents the attack of the mosquito (indicating). Suppose it alights upon a person whose blood is infected with malarial parasites. It sucks it out and into its stomach there certainly go some of these parasites. Here (indicating) we find we get red corpuscles which contain the parasites, each of different sorts, undergoing different changes. As a matter of fact they are of different sexes. These (indicating) occupy the whole corpuscle and become globular. This parasite (indicating) breaks up into a considerable number of parasites, each with a tail-like projection. They unite with the globular parasite, which then becomes a fertilized cell. It then grows, and in turn divides into a great many others, and the division goes on until a stage of that sort (indicating) is reached, and

then those nucleii become surrounded by certain parts of the protoplasm, and this by an outer skin or wall, which in turn breaks down, and the parasite escapes into the blood.

"These parasites are carried in the salivary gland or spit gland of the mosquito, making their way through this passageway (showing enlarged picture of mosquito), which leads the saliva of the mosquito down to the beak. Suppose that these changes have gone on, requiring, as they do, about two weeks, and this mosquito now has its salivary glands permeated with those parasites. They have also penetrated the ducts. This mosquito alights upon a person free from malaria, and thrusts its beak into that person, and in order that the blood may not clot, injects some of its saliva into the blood of the person. With that saliva goes the parasite, and the parasite fixes itself to the corpuscle, and the cycle begins again. Thus malaria is carried by the mosquito; and we have in New Jersey considerable malaria. Four hundred and eighty-three cases were listed last year, and I think a remarkable thing is that three hundred and sixty-six cases were listed in one county. Your county may be practically free from malaria. It may have been for the past twenty-five years; yet I can see no reason why the malarial species of mosquito may not make its way into your county in great numbers, with the result that your county will have three hundred and sixty-six cases instead of the other county. While your skirts for the present may be free, there is no reason to consider that in the future they will remain free.

The mosquito damages New Jersey in the loss of investments, it damages New Jersey as a disease carrier, it damages New Jersey by holding back the use of the salt marsh for every condition which makes for low yield of hay in the salt marsh makes for high yield of mosquitos, it damages New Jersey far more than in any other of these ways, in the holding back of values in regions where the mosquito is abundant. Land is exceedingly cheap on the Jersey coast. It is true there are spots where land is high; but some of the worst mosquito spots are the finest places for summer homes, yet those places are not used for summer homes, simply because the mosquito is there. The mosquito is holding back the sale and development of these spots that would be used for summer homes, and that land can be bought at exceedingly low figures to-day. The salt marsh in its water-logged condition, will sell for all the way from fifty cents to twenty-five dollars an acre. That same



marsh, if drained in a way to get rid of the mosquito, will produce, we will say, twenty dollars per acre income per year in salt marsh hay; and land that will produce at that figure is bound to double, at least, the value mentioned. But the loss due to the holding back of the values of the Jersey coast through the mosquito is incalculable. I have no doubt that we are losing millions of dollars every year that we let this condition continue.

"In speaking of the methods of attack, we must first consider the history of this creature before we can understand how the thing can be handled. This (indicating) represents the egg mass, this, the frame that floats the egg mass. The salt marsh mosquito lays its eggs in mud at the edge of a pool, and they do not hatch until covered by water. From these eggs come the well known wrigglers (indicating), the same whether the eggs are floating on the water or laid in the mud. In about five days we find that these wrigglers have been transformed into big headed pupae (indicating). From those pupae the mosquitos are born. So it takes in the neighborhood of two weeks for the mosquito in warm weather to go through its life cycle. As a matter of fact, in winter time, the salt marsh mosquito is found in the form of eggs in the mud, while the house mosquito may be found in our cellars or outhouses as adult mosquitos passing the winter so.

"These different kinds of mosquitos have different habits. This is especially illustrated by the fact that salt marsh mosquitos, breeding on the salt marshes, rise and are sometimes carried by the wind forty miles inland. Of course, they are also carried to sea, but here we never find them. I want to give you a general idea of the territory infested by the salt marsh mosquito. Before there was any ditching of the salt marshes the mosquitos bred from Secaucus in the north to Salem county in the south, covering a territory forty miles back from the coast; at times they appeared in great numbers, at other times they were not to be seen. Winds have a great deal to do with the occurrence of these mosquitos. The swarms rise and are carried far inland and never return. The creatures are unable to breed in fresh water; they simply die. What their origin, what use their migration can serve, no one can say; yet it is a fact that there are now probably in the city of Montclair, salt marsh mosquitos, come all the way from the coast, while in Paterson the same thing is true. For example, some come

from the Raritan marshes, some from the Newark Bay marshes; not many, not anything like the number that used to come, for the salt marshes have been ditched, and comparatively few get out, but the work is not yet perfect enough to prevent all from getting out. If this happens in the northern part of the State, where the marshes are largely drained, what must be the condition in South Jersey, where there is practically no drainage and where mosquitos breed unhindered? And those of you who live in Cape May County, Atlantic County, Cumberland County, Salem County, unless you are immune to the mosquitos, know what it means. It means that you will have no mosquitos one evening, and the following morning, following a rain, the air will be full of them, so that life is almost unendurable. That is the salt marsh mosquito.

"I will now show you pictures of several breeding places—in Cape May County—Gravesend—Atlantic City—I am glad to say that *this* place has been done away with; that was taken several years ago—a characteristic pool on the shores of South Jersey—this is a pool in which there is comparatively little mosquito breeding, because it is connected with the ocean, it is deep, and fish are able to live in it—here we have filled, and got rid of the mosquito. This is a picture of a dredge in the Passaic River, in the operation of sucking the mud from the bottom of the river, and delivering it together with water into the meadows, where the water is confined by dikes and the mud settles. This is one of the best methods of getting rid of the mosquito, but it is expensive, and is practical only where you have land of value. This is another method, that of cutting ditches so as to connect all the pools of the meadow with the ocean, that the water may come in and out. This is a ditch ten inches wide and thirty inches deep. The sod is taken out in great pieces, weighing each about two hundred and twenty pounds. Here we have a ditch of double width. The 10 x 30 ditch is the smallest that is made, but where several of these ditches come together we have to have double width. It is made deep because it does not fill up so rapidly. If it is cut shallow we find that the mud gets in the bottom, and presently it is so near the top of the water that the cat-tails begin to grow, and the ditch is done for; it fills up.

"This is the Manahan spade, cutting a ditch 10 x 30. Here men are in the operation of raising the sod, cutting the ditch

and pulling it up—here they are in the operation of raising the sod; this is a double width ditch.

“This is a machine for ditching purposes, that cuts much more rapidly than by hand, cutting seven sod per minute. It cuts sod weighing over four hundred pounds. These pictures show the various stages of its operation. These ditches in three or four years begin to fill and it is then necessary to clean them, making use of potato hooks for that purpose. Where the water runs very slowly, where the level of the meadow is low, these ditches fill more rapidly, and it is necessary to clean them more frequently. Where the level is high, and there is a flow of water, the tide cuts the ditch ever deeper. The cut ditches on the Keyport meadow are deeper to-day than when they were made. We find that the ditches close at the top, the sides coming closer together year by year, but at the bottom they are frequently wider than at the time they were cut. I have found a ditch ten years old with the tops fully grown together so that you could not tell there was a ditch there, except for the fact that there was a little line of high grass. On opening such a ditch you will find that it is wide open at the bottom. This was ten inches wide and the walls were as clean and smooth as if they had been polished, and the bottom clean and hard. This is true, of course, where the tide has the opportunity to flow in and out vigorously.

“This (indicating) is the method of handling pools in the sand hills. This is in Beach Haven. We have filled the small swamps with sand, drained the larger ones and put fish in the pools. This kind of work we have been doing right down the coast. We find that since this work began property along the shore has increased in value five and one-half million dollars. We find that in the salt marshes the increase in value has been about fifteen per cent., but when we get down into the residence districts, the increase in assessments has reached in some cases as high as three hundred per cent., indicating that it is freedom from the mosquito that has brought about a large share of this increase. An increase of fifteen per cent. as the result of the drainage of the marshes indicates that the freedom from the mosquito has cut a very material figure in the large increase in values of residence property.”

Dr. Headlee then showed pictures of several breeding places, and illustrated the method of treating such places with oil; he



then showed moving pictures showing the work being done,—digging the ditches, cleaning them out with potato hooks, the ditching machine in operation, treatment of local breeding spots with oil, the effect of the oil upon the wrigglers, the growth of the mosquito from the pupae, mosquito enemies, etc.

A motion was made, seconded and carried that the thanks of the Society be extended to Dr. Headlee.

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COMPLICATIONS OF THE OPERATION FOR REMOVAL OF TONSILS.—Charles W. Richardson, *The Laryngoscope*, June, 1913. *Hemorrhage*. The writer states that an error in technic and accident are more frequently the cause of this complication than hemophilia. He states that there is less danger when the operation is performed by finger enucleation. *Hyperpyrexia* without known cause is sometimes a complication. We should not be unprepared to have a case with this complication end fatally. Wishart reports a case of a young girl, who, after the operation, had a temperature rising to 107 degrees and who died twelve hours after the operation. The author had a similar case in a child of four who died a few hours after the operation. He has had two cases result in *infarct of the lung*, one in a man 45 years of age, who, six days after the operation ran a septic temperature with a constant cough, and complained of great pain in the base of his right lung. Some weeks later an abscess developed and an operation was performed with a favorable result. The other case was a young woman of twenty-four. Ten days after the operation she developed a severe cough and later expectorated large quantities of pus. This case recovered with the administration of hexamethylenamia.

*Mild sepsis* enduring for a few days is a frequent complication of tonsilectomy. Sonntag reports a case developing torticollis with swelling of the knee and right wrist, death occurring from general infection. Dean has reported three cases, one dying of general sepsis; a second was a case of cerebral thrombosis with recovery, which did not manifest itself until fifteen days after the operation.

*Emphysema* is rather a rare complication. One case is reported by Parrish and the author had a mild case develop in his practice. *Pneumonia and pleurisy* as sequelae are not usually reported but there is a sufficient number of cases to indicate that such complications do occur. The author had two cases of pleurisy, which recovered, and one case of pneumonia. Coley reports three cases of septic infection of the serous membranes and Putnam has seen two cases of meningitis. Among other complications may be mentioned disturbance of the nervous system, status lymphaticus, a dermal rash appearing a few days after operation and local disturbances such as edema, hematoma, abscess, torticollis, injuries to the surrounding parts especially the uvula, and infection of the middle ear and of the cervical glands.

## EDITORIAL

### THE RADIUM FAD.

THE medical profession and the public seem to be determined upon having some magic cure-all for the various diseases and infirmities that afflict the human race. This tendency, which has manifested itself in mankind from the most remote antiquity, was never stronger than it is to-day. Radium is now the object of adoration, and the virtues attributed to it by those who are interested in exploiting its use, as well as by those whose vivid imaginations supply the sincere testimonials of the wonderful cures it produces, are not surpassed in any works of fiction, ancient or modern.

We do not wish to be understood as meaning that there is no possible field for the use of radium in medical practice, but we do protest against the absurd nonsense that is daily published in regard to the therapeutic properties of this agent. At the present time all we know is that radium emanations, if concentrated upon living tissue for sufficient length of time, will destroy this tissue. A piece of red hot iron will do the same thing. Whether this property radium possesses of devitalizing or destroying tissue can be utilized in a practical way in medical or surgical treatment yet remains to be proven.

At the present time, no one seriously believes that radium has proved itself superior to the knife in the removal of growths of benign or of malignant character. In fact, the whole subject of the practical utility of radium in the surgical sphere is as yet in a purely experimental stage.

As to the remarkable claims that have been made regarding the value of radium in arteriosclerosis, gout, rheumatism and almost every other human ill, we believe that these, in the main, are gross exaggerations and that the emanations that have brought about favorable results in most of the cases reported have been from the mind of the patient and of the physician rather than from the radium.

Probably no aspect of the radium craze is more remarkable than the attempt on the part of those controlling the sale of

mineral waters to claim that the beneficial action of these waters is dependent upon their radio-activity. The astonishing rapidity with which the old-fashioned lithia waters became radio-active, is worthy of particular note. So popular has the craze for radio-active mineral water become that the United States Department of Agriculture has issued a warning to the public against the use of fraudulent waters of this character. The Government chemists state that in the majority of instances these waters contain no substances possessing radio-activity at all and that what little radio-activity some of them possess is due almost entirely to radium emanations, which disappear from the water shortly after it has been bottled. Experiments have shown that within four days after bottling, the radio-activity has diminished fifty per cent. and within a month it has practically disappeared.

The Department of Agriculture is now investigating a number of these waters with the object of securing evidence that can be made a basis of prosecution for misbranding. It has been found that the imported waters particularly contain labels which are absolutely misleading to consumers as to their real or supposed curative properties. The circular sent out by the Government closes with this statement: "The Department fears that unless the public is warned, the fraudulent trade in so-called radio-active waters will develop, just as the fraudulent trade in other mineral waters has developed to the point where people with strong imaginations will supply their bottlers with all sorts of testimonials asserting that these supposed radio-active waters have effected wonderful cures."

G. H. W.

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#### THE PRESENT STATUS OF MEDICAL EDUCATION IN PENNSYLVANIA.

DURING the past few years an effort has been made all over the country to raise the standards of medical education and the preliminary requirements for admission to medical schools. This movement has been brought about in response to a demand on the part of the public for more competent physicians and has been concurred in by the vast majority of the medical profession. The report of the Carnegie Foundation, published a few years ago, did a great deal to stimulate activi-



ties in this direction and was, no doubt, the direct cause of the closure of a number of second rate medical schools.

While our observations lead us to believe that the vast majority of the medical profession are in hearty favor of any reasonable efforts to raise the standard of medical education, we have occasionally met with a medical practitioner who questions the advisability of such a course and is at times disposed to condemn medical schools for insisting upon what he terms "too strict" requirements for admission and graduation. Without entering into a discussion of the desirability or undesirability of higher standards of medical education it is only fair for the physician who is inclined to criticise the steps that have been taken in this direction to remember that the medical schools have no choice in their attitude in this matter. The matter of preliminary education in the State of Pennsylvania, at least, is entirely in the hands of educational authorities of the State and they alone can determine a man's fitness to enter upon a medical course. The curriculum must be arranged to meet the demands of the Board of Medical Education and Licensure and any attempt on the part of a medical school to evade its responsibilities in this respect would, no doubt, prove highly detrimental to its growth and progress. The truth of the matter is that whether the individual physician may regard it as desirable or not, public opinion and forces both inside and outside of the profession have demanded radical and important changes which affect both the preliminary and actual training of the prospective physicians. Both medical boards and medical schools have been called upon to meet this demand and we believe that on the whole they have done so in a manner which commends itself both to the public and to the profession.

During the last session of the Legislature of Pennsylvania, a bill was passed and signed by the Governor which requires that after January 1, 1914, the applicant for admission to a medical college in the State of Pennsylvania must have one year of college credits in chemistry, biology and physics in addition to the standard four year high school course. This extra year may be taken in any school or college having the proper facilities and, inasmuch as there are certain advantages to the student in taking this preliminary course in the college in which he desires to pursue his medical course, the Hahnemann Medical College of Philadelphia, and, we are informed,

a number of old school institutions, have arranged to conduct such a course on the lines laid down by the Department of Public Instruction.

The same law above referred to also requires that graduates of medical schools must serve one year as an interne in an approved hospital before they are eligible for license to practice medicine. As a matter of fact the majority of graduates of the Hahnemann Medical College have complied with this requirement for a number of years and this provision will impose very little hardship on medical institutions or their graduates.

The new law also contains provisions giving the Bureau of Medical Education and Licensure control over the "minor branches of drugless medicine." This includes chiropractors, mechano-neuro-therapists, psychotherapists, bonesetters, and, in fact, all drugless methods of treating the sick, except the osteopathic, which is under the control of a separate board.

Few physicians have any idea of the extent to which these cults have increased. The Bureau has already had applications submitted to it from thirty-six "varieties" and we know of at least forty more that come under the same heading. Some of these men are competent and ethical in their particular line; others are uneducated charlatans of the worst sort, but all have this in common, namely, that they insist they have the only universally applicable, natural, unfailing method of curing disease. To solve this problem in a way which shall protect the public and be just to those seeking a license to practice these various cults, is a matter that will require much thought and attention.

In closing, we would impress upon all physicians knowing of prospective students of medicine, that they urge upon them the importance of securing the proper preliminary education. Remember that no man is eligible for admission to a medical college in the State of Pennsylvania after January, 1914, unless he shall have had the equivalent of one year of college credits in addition to his regular high school course.

G. H. W.

## GLEANINGS

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THE DIAGNOSIS OF SOME COMMON SYMPTOMS IN CHILDHOOD.—C. V. Kebbell, in the *Practitioner*, states that diagnosis in children rests largely on the result of clinical examination. The general appearance and expression of children who are ill are points which should be studied well. A child's face is frequently a clear index of the severity of the illness, or indeed of the actual complaint from which it is suffering. Small children will often resent examination and the opportunity should be taken of carefully but not too openly noting the general appearance whilst questioning the patient. As examples of points to be gained from a casual inspection I may mention lung disease, the flushed face and working alae nasi of a case of pneumonia, the anxious expression and rather labored breathing of a case of broncho-pneumonia, the sallow complexion and difficult respiration associated with empyema. The severity of a case of enteritis can be judged by the sunken appearance of the eyes and the fontanelle and the pinched inelastic state of the skin. A peculiar meditative look is seen on the face of the child with tuberculous meningitis and a dull, heavy appearance in typhoid fever or pyelitis. Extreme pallor will suggest a severe infection, diphtheria, reumatism or one of the anemias of infancy. The pinched, anxious look of the face with perhaps a slight tendency to cyanosis will suggest the severity of an abdominal condition such as peritonitis. The red, crusted eyelids, running nose and blotchy appearance of morbilli, and the puffy eyelids, with perhaps subconjunctival hemorrhages and bloated face of the child with severe pertussis are often met with. The cry of the infant may also assist in coming to a diagnosis, the improperly fed baby has what can only be termed a "hungry cry." Screaming, on the other hand, may be occasioned by colic, brain disease or otitis media. Crying out and handling the limbs apart from local injury or disease may be associated with a general disturbance of nutrition as in rickets or scurvy. The character of the cry is then suggestive, the hoarse voice of laryngitis, the weak wail of the feeble infant, and the gradual loss of voice in diphtheritic laryngitis.

The cough should also be noted, the paroxysmal cough of pertussis, the hoarse barking cry in laryngitis, frequently met with at the onset of morbilli, the short, persistent, often painful cough of pleurisy and pneumonia, and the inability to cough when the lungs are being choked with secretion as in severe bronchitis. All these points may be made out before proceeding to examine the child, and needless to say the most unpleasant part, looking at the throat is left to the last. It is usually advisable whilst examining the chest to let a small child sit on its mother's lap, and it is often best to listen to the back first, so as not to alarm the child by the sight of the stethoscope, and to accustom it to the feel of the chest piece. It is to be remembered that the apex of the heart in children under four



years of age is normally situated in the fourth space and often somewhat outside the nipple line. It has reached the adult position by twelve-fourteen years of age. The pulmonary second sound, as opposed to the case in adult life, is normally rather louder than the aortic. Second examination of the lungs in children is extremely deceptive as regards the physical signs obtained. The breath sounds in small children are usually very distinct and normally rather harsh or "puerile." In comparing the sounds heard on the two sides of the chest, most reliance is to be placed on the "pitch" of the breath sounds, rather than on the doubtful query of prolonged expiration or bronchial breathing which is unaccompanied by any marked impairment of the percussion note. Bronchial breathing may be heard at the apices in quite normal children who are breathing deeply with their mouths open. The abdomen is normally prominent in infants owing to the size of the liver which extends half an inch below the costal margin in the right mammary line, the spleen, however, should not extend beyond the costal margin.

Babinski's sign giving a normal flexor response in the adult, is extensor in children under three; by that age in a healthy infant it should have become flexor. If, however, in premature or ill developed infants who are late in walking, a flexor response is obtained, Thomson states that it is of good omen because it indicates that cerebral spastic diplegia is not in process of development and therefore justifies the prediction that such children will ultimately be able to walk.—*American Medicine.*

**GREAT TENACITY OF LIFE.**—Turnbull notes that the case of the French Zouave who lived for some time after practically the whole of the head except the brain had been removed by a cannon ball is one of the classical instances of tenacity to life. Weinlechner in 1881 reported that a man had lived and been conscious for twelve hours after a fall and injuries which included fracture of the cervical spine, with laceration of the cord, paralysis (motor and sensory) of all the limbs, rupture of the sternum, bleeding into pericardial and abdominal cavities, and laceration of the spleen. Erichsen reported the case of a man who, after leaping a distance of sixty feet down a hoist, lived for ten days, although suffering from fracture of seven ribs, perforation of the apex of the right lung, tearing of the pericardium, complete fracture of the first lumbar vertebra, and pulverization of the right os calcis. D'Arcy Power read a paper in 1890, indicating that considerable laceration can take place in the spleen and in the kidney with very slight symptoms, unless a large blood vessel is implicated. If urgent hemorrhage does not immediately follow injury the most extreme internal injuries can often be undergone with a minimum manifestation of shock. The following case that came under the author's observation is cited to bear this statement out, and emphatically illustrates the powers of tenacity of life in the human frame: The case was that of a dock laborer aged 45 years who was admitted to the hospital nine hours after he had fallen down the hold of a ship. This man walked half a mile after receiving a fractured skull, extensive fractures of the ribs, pulping of the spleen, pulping of the kidney, and lesions in the vicinity of the solar plexus. A bowlful of blood had probably been passed by the

urethra from the ruptured kidney. The patient died one hour after admission to the hospital.—*British Medical Journal*.

ONE THOUSAND CASES OF SYPHILIS TREATED WITH SALVARSAN.—Kilroy, in *The London Medical Lancet*, states that 2,147 injections were given to 1,000 cases—the first injection on August 16, 1911, and the last on November 8, 1912. No deaths have occurred. Seventeen cases received only one injection; 865 cases received two injections; 75, three injections; 40, four injections; and 3, five injections. There were three cases of pain, stiffness, and swelling of the arm, causing some loss of service, but no permanent damage. In one of the cases quite recently he felt confident that he injected 250 cc. of the solution into the space between the vein and its sheath. The reactions were on the whole very mild—twice a temperature of 104.8° F. The great majority showed no rise of temperature. A few reactions were delayed to the next day. No reactions occurred on the day of injection. Herxheimer reactions were not very common, and it was difficult to separate them from arsenic rashes. He could not satisfy himself that they were more common in one particular type of case than in another, except that possibly florid early secondary cases provide them in greatest numbers. Very fibrous non-vascular tissues are resistant. Florid secondary syphilis gives the most dramatic results. There were three cases of pain, stiffness, and swelling of the arm, causing more loss of service, but no permanent damage.

Occasionally resistant ulcerations (particularly those of the pharynx) are met which improve up to a certain point, and then cease to improve, only to yield to vaccine. At times, even though the polymorphous rash of the syphilitic disease disappeared promptly there persisted patches of eczema or infections of other types, which later cleared up under vaccine.

The needle used was of tantalum fixed in a modified McDonagh's holder, this being harder than steel or platino-iridium, not rusting, nor expensive. As to pace it is stated that one operator can deal with 12 cases an hour provided he has very skilled assistants. He has equaled 21 injections in 1½ hours. About 50 per cent. of the cases examined after having had salvarsan gave a negative Wassermann.

Of the 2,147 injections given to 1,000 cases with 13 invalidings, there were no deaths, and 22 clinical relapses readmitted to Kilroy's hospital, two clinical relapses admitted to other naval hospitals, and two occurring in ships. Of 901 cases receiving two injections, 21 cases reached the hospital as relapses, two were known to have recurred in ships, and two have been treated in other naval hospitals.

Of 68 cases receiving three injections, one case reached the hospital as a clinical relapse.

In 14 cases receiving four injections, no case reached the hospital as a clinical relapse.—*Charlotte Medical Journal*.

THE TREATMENT OF INFLAMMATORY ADNEXAL DISEASES.—Krull says this is one of the most important chapters in gynecology. According to the modern view the expectant conservative method is demanded. The treatment is easier if an exact diagnosis can be made, whether tubercular, gonorrhoeal or puerperal. Tubercular inflammation cannot always be di-

agnosed with certainty. In gonorrhoeal disease with circumscribed collection, vaccine therapie promises much; and yet a pure gonorrhoeal infection is rare since there is mostly a mixed infection. If the etiology is obscure appendicitis or chronic constipation may be the cause. The cases should really have hospital observation and care in order to determine whether the treatment should be continued as conservative or operative. Acute cases must be treated in bed with ice bags; later, hot douches are called for. If the inflammatory process tends to relapse the case should be operated after an afebrile period. Swellings into the vagina may be punctured; otherwise the abdominal route should be used. If drainage is called for by a raw area in the pelvis, the drain had better go into the vagina. Drainage is not indicated if the peritoneum is intact.—*Zentralbl. f. Gyn.* 1912—1655.

THEODORE J. GRAMM, M. D.

CAESARIAN SECTION IN INFECTED UTERUS.—Mueller, of Munich, has described a successful method of operating in these cases whereby the classical Cæsarian section, which after all is the best, may be used with success. In the preliminary comments of the extra-peritoneal method of operating, he quotes Schauta as saying that he cannot regard any operation as the operation of the future, which is conceded to be complicated, that suppuration is apt to occur, with prolonged treatment in bed and that the infant mortality is great, and the permanent results doubtful. In clearly uninfected cases we have surely no reason to depart from the classical operation.

The method successfully followed by the author consisted in modifying classical operation so that the incision into the uterus was made somewhat to the side. Infection of the peritoneal cavity was avoided by the use of many pads. After the uterus was emptied, its cavity was mopped out with 92 per cent. alcohol, with which also a drain was saturated and passed out of the cervix. Rapid contraction of the uterus is hereby produced. After suture of the uterine wound, the parietal peritoneum is attached to the uterus all around the line of uterine suture so that any wound secretion may find its way out of the abdominal cavity through the partially closed and packed abdominal wound.—*Zentralgl. f. Gyn.* 1912—1645.

THEODORE J. GRAMM, M. D.

CHRONIC CYSTITIS OF THE NECK OF THE BLADDER.—Garceau says the main symptom is frequent urging to urinate with or without pain and tenesmus. The urine may be quite clear with little or no sediment, or it may be cloudy with much pus and mucus. The exact diagnosis can only be determined with the cystoscope. This shows sometimes only a redness of the trigonum which is usually continued into the posterior part of the urethra. Purulent or mucous deposits are often seen, rarely ulcerative. The mucous membrane is frequently swollen and there may be polypoid excrescences, so that the mucosa may appear velvety or there are fissures in the region of the sphincter. Small cysts with clear contents may be present. Two forms of disease may be distinguished. In the first variety the pathological changes are as above described; in the second the



epithelium is unchanged and the tissue alterations are in the deeper layers where abundant deposits of lymphocytes are found. In the etiology of cystitis colli, just as in many other gynecological affections, congestions play an important part. The chronic hyperaemia of the bladder favors infection. An unclean catheter may also cause the disease. The treatment consists in the use of urotropin, copious drinking of fluids and bladder irrigation followed by the instillation of 10 to 20 cm. of 10 per cent. protargol solution. Knorr thinks the best results are obtainable from a 1 or 2 per cent. nitrate of silver solution after first eucainizing the bladder. Polypi must be removed with the snare or thermocautery, and fissures by dilating the sphincter or cauterization. The author has never seen good results from the curette. When the deeper layers of the bladder are affected a vaginal cystotomy may be required.—*Abstr. Zentralbl. f. Gyn.* 1912—1564.

THEODORE J. GRAMM, M. D.

OCULAR INJURIES IN CHILDREN.—The authors have collected 229 cases of injury in the 23,000 patients seen in about six years. This gives about one per cent. of injuries. In children under two years the accidents are mostly due to the children falling into the fire, to frying fat splattered into the eyes and to falls. Between two or four years the accidents are mainly due to awkward movements and falls while holding knives, forks, etc., in the hand. Up to this age the accidents occur with about the same frequency in both sexes, but from this age on about three male children are injured for every female. This is due to the dangerous pastimes and the quarrels indulged in by boys, the plays with pocket-knives being especially dangerous. From the age of fifteen the accidents are the same as with adults.

While infection may take place as easily in a child as in an adult, the fact that hypopyon is rare after light corneal injuries is explained by the lack of lacrimal stenosis in children, and the absence of infecting material in the lacrimal sacs.

As to prognosis, the contused wounds are the worst, three out of six cases having been lost through panophthalmitis, the other three through iridocyclitis, and all leading to the removal or exenteration of the eye. Punctured wounds are nearly as bad, giving rise to panophthalmitis in one of five cases, three showing iridocyclitis, and one recovering. In eight cases of incised wounds there was one resulting in panophthalmitis, two in iridocyclitis, and five in recovery.

The treatment was the same as in adults. In view of the frequent infection in these cases, it is a matter of surprise to note the absence of all reference to the use of antitoxic serum, etc., which has been used with alleged great advantage by other French authors.—*F. Terrien and A. Dantrelli. Ach. d'Ophthalmologie.*

WILLIAM SPENCER, M. D.

## Monthly Retrospect

### OF HOMOEOPATHIC MATERIA MEDICA AND THERAPEUTICS

CONDUCTED BY DR. DONALD MACFARLAN  
PHILADELPHIA

GELSEMIUM AND PELLAGRA.—In a recent issue of the *Charlotte Medical Journal* an original communication contributed by Dr. Roy Blosser, of Atlanta, Georgia, is of great moment as it bears closely upon the use of gelsemium in the treatment of pellagra. Gelsemium in potency has always proved a highly prominent drug in homœopathic practice and the splendid results obtained from the crude drug action, as evidenced by Dr. Blosser's article, would point to its still greater value in the dynamized state.

So far as can be determined from the English literature on pellagra the administration of gelsemium in this disease had not been tried previous to its use in the five cases reported by Dr. Blosser in November, 1912,

Of the nineteen cases included in the present report, eleven occurred in the practice of Dr. L. P. Pharr, of College Park, Ga., to whom Dr. Blosser acknowledges considerable indebtedness for aid in carrying out the treatment and in keeping records of the cases. This series of cases includes the five previously reported.

While admitting that there has not been sufficient time to fully demonstrate the value of gelsemium in the cases reported on account of the exceedingly chronic nature of pellagra and its annual remissions and exacerbations, the following facts seem to indicate that the use of this drug will prove to be of great value in the treatment of pellagra. (1) Every case so treated, excluding patients numbers 18 and 19 whose condition appeared hopeless from the start, has made rapid improvement in every respect. (2) Up to June 10th none of these had shown any indication of a recurrence further than some degree of malaise during the first warm weather; other cases in this locality have, during the same time, experienced a return of the eruption and other pellagrous symptoms. (3) While some of Dr. Blosser's patients are not yet cured, he feels justified from past experience in assuming that a continuance of treatment will give as good results in these as in the earlier cases treated, inasmuch as they do not appear to differ in any essential particular. (4) The remedy seems to be effective at any time of year; those patients treated this spring have responded well to the treatment, although they have been somewhat depressed by the warm weather and have not gained in weight as rapidly as those treated during the cool weather. (5) Thirteen of this series had previously been diagnosed and treated as pellagra; eleven of them had been unable to see any benefit from the previous treatment and had grown worse.

Two had improved for a time but for six or eight months had been unable to see any further benefit from the treatment.

In order to eliminate all doubt as to diagnosis, only those cases which had shown the characteristic eruption have been included in the above group. Dr. Blosser has also treated about twelve cases in which the skin symptoms were lacking or atypical but in which there seemed to be sufficient evidence to warrant a diagnosis of pellagra—the so-called “pellagra sine pellagra.” These cases have been of a decidedly chronic type, giving a history of gastric and nervous symptoms for a number of years, and while they have done very well on the same treatment and diet as prescribed for the other cases, the improvement has not been nearly so rapid.

All of the cases included in this tabulation suffered from mental depression, despondency and impaired memory; in several orientation was, at times, markedly affected. Only two could be classed as insane (cases 18 and 19).

Vertigo has been a prominent symptom in all of Dr. Blosser's cases. In one (case 14) the patient was afraid to go out on the street on account of attacks of dizziness which would come on so suddenly that she would fall. Marie states that these attacks are termed pellagrous spells by those living in pellagrous districts.

Menorrhagia, and metrorrhagia have occurred frequently. Of the fifteen cases in females, two had passed the menopause and, of the remaining thirteen, six had suffered from some degree of excessive uterine flow. In three cases this had resulted in profound weakness from partial exsanguination. Gelsemium in attenuated form has proved a very valuable remedy in partially paralyzed states and drooping of the upper eye lids.

LITHIUM POISONING.—Cases of lithium poisoning are very rare. In the *Journal of the American Medical Association* of March 8th, Mr. S. A. Cleaveland has described toxic symptoms which differ in some respects from those hitherto described. During an investigation on uric acid under Professor Haskins he took rather large doses of lithium chloride. In a first experiment he took 2 gm. in a glass of water three times in the day after meals and a dose on the following day, making a total of 8 gm. in 28 hours. Three or four hours after the first dose he suffered from slight dizziness and fulness in the head. After the second dose he noticed nothing. Soon after the third dose vision was much blurred and nothing smaller than the largest headlines of a newspaper could be read. There were marked dizziness and tinnitus. The fourth dose was taken at night and the dizziness was such that the room seemed to go round all night and sleep was almost impossible. Next morning he was much prostrated. The ocular symptoms were increased and dizziness, weakness, and tremors were so intense that he had to go to bed. The ocular and aural symptoms lasted about 36 hours after the last dose and weakness and tremors for five days. At no time were there gastro-intestinal symptoms and the appetite remained good. Several months later the experiment was repeated to make certain that the effects were due to lithium. Only two doses of 2 gm. each were necessary to bring on the dizziness, tinnitus, and blurring of vision. The general symptoms were much less marked than before, but there was some weakness for a day or so. According to the literature of lithium poisoning



the common symptoms are marked prostration and gastro-intestinal irritation. The latter was absent in this case. The striking symptoms, resembling those of cinchonism, do not appear to have been described by any previous writer. They may have been due to the large doses taken, which were twice or thrice those which seem to have been taken in any recorded case.

From a consideration of the above toxic states induced by the drug the homœopathic preparation would be of use in dizzy states accompanied with ringing in the ears and a blurring of the vision. In many respects, from the evidence adduced by Cleaveland it would closely resemble china in its action. Lithia carb., one of its other salts, in high attenuation has been found highly curative in barbers' itch; circular porrigo provings of lithia carb. caused in provers the following symptoms—a rough rash all over the body; much loose epithelium; tough, dry itchy skin and turbid urine. Both cheeks are covered with dry, bran-like scales. The above data taken from Malcolm Macfarlan's "Observations with High Potencies."

THYROID PREPARATIONS FOR STERILITY.—Weil mentions the astonishing results of hormone physiology, pathology and therapy, and selects for special consideration the apparent correlation between the thyroid and ovary, which comprises not merely one but a series of possibilities, some antagonistic, some complementary or synergistic. During menstruation and pregnancy the thyroid swells, while in castrates the latter organ may be seen to be atrophic. It occurred to the author to test thyroid preparations in primary sterility assumed to be due to ovarian insufficiency. A barren woman with simple goiter received thyroid preparations on general principles and in the course of two or three months became pregnant. The author then exhibited the remedy to two other barren women who aside from a slight enlargement of the thyroid showed nothing to suggest a reason for failure to conceive. After several months conception took place in both women. Of four pregnancies while taking thyroid two ended in abortion while one conception is recent and the only case which went to term required forceps. Whether these results are coincidences or indicate a general insufficiency for child bearing is not argued. There appears to be no doubt that the thyroid hormone artificially supplied determined a physiological congestion of the ovary which promoted conception. On the other hand none of these women appeared to have had any trouble in connection with ovulation and menstruation, so that a rationale for conception is not suggested.—*Medical Record*.

CHIONANTHUS VIRGINICA AS A LIVER REMEDY.—This remedy is indicated by clay-colored stools, high colored or brown urine, yellowness of the conjunctiva and the skin, uneasiness or pain in the region of the liver or right hypochondrium, abdominal pains or colic, and great prostration. It is one of the best remedies in jaundice, when due to functional disorders of the great hepatic gland. It has the property of assisting in the prevention of gall-stones, and in their expulsion. It is indicated in slow convalescence following exhaustive diseases. It is useful in hypertrophy of the liver, consequent on obstruction of its ducts, or of a malarial character, and also in bilious colic.—*Homœopathic World, London*.

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## THE FAILING HEART.

BY

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It would be impossible within the limits of a paper such as this to cover the whole ground of the subject of heart failure. "Heart failure" as a cause of death has been much abused in the past by those who were either too lazy or too little learned in their profession to determine the underlying cause. The heart being a muscular organ and its function that of a pump, to establish and maintain the bodily circulation, it follows that any condition that impairs that function is a cause of heart failure. The conditions, therefore, may be local or peripheral, acute or chronic. Without attempting to enter deeply and in detail into the various causes of incompensation, they may be classified roughly as follows:

The acute causes are those resulting from violent exertion or great mental strain, either in the normal heart or one previously weakened by disease.

The chronic causes are much more numerous. Among these

may be mentioned myocardial weakness from disease of the heart muscle itself, from age, and from sclerosis of the coronary arteries. Valvular lesions or narrowing of any of the orifices are potent factors in cardiac failure because of the extra labor they impose upon the heart.

Of the peripheral causes may be mentioned changes in the blood stream, due either to obstruction, as from pneumonia with pressure of an exudate upon the pulmonary capillaries, or from pulmonary embolus; and hypertension due to arteriosclerosis, or cardio-vascular renal disease.

From this brief outline it follows then, that to discuss in detail the immediate and remote factors in the failing heart would be to run the gamut of all the abnormalities that may befall mankind. However, from a practical view point in determining the extent of damage in a given case and the treatment, we are guided by the axiom that the one, the final test of a heart is its efficiency. As long as the heart muscle can overcome any difficulty, either in the organ itself or peripheral, as long as it can perform its function in maintaining the normal circulation, no symptoms arise. But the moment it fails, however slightly, to do its proper work there are manifest certain symptoms of heart failure. Whatever form these symptoms take they all point to one condition, embarrassment of the heart muscle and finally exhaustion.

The heart muscle cells have certain peculiar functions which can only be enumerated here. They are: *Excitability* to stimuli whether from within or from the nerve centers; *conductivity*, which enables them to pass the contractile stimulus on from cell to cell; *contractility*, the force of which is largely dependent upon the length of the preceding period of rest; *tonicity*, which prevents the muscle fibres from relaxing to their full length, and *co-ordination* of the various functions of the heart, which causes the contractions to sweep from above downwards and gives it its full force as a pump, in maintaining the circulation. The chief factor, however, in every heart condition is its reserve force and every case of heart failure is a result of the exhaustion of this reserve force. Upon the recognition of this obvious but often overlooked fact depends the prognosis of every case. And the conservation or restoration of this force should determine an essential part of the treatment.

Although we are not able to define just what reserve force is



we all know that it exists and that its diminution means more or less disaster impending. According to Benno Lewy: "The reserve strength of the heart enables the organ to perform thirteen times the amount of work which it exerts when the body is at rest. This increase is effected partly by an increase in the quantity of blood that is propelled during a single systole—the amplitude of contraction—and partly by an increase of the number of contractions in a unit of time."

An important point in this connection is this. The heart gets its own nutritive blood supply during diastole.

When the heart's activity is increased from any cause the increase is at the expense of the diastole and hence long continued hyper-activity must result in muscle deterioration owing to lack of proper nourishment. Any condition that permanently, or over a long period, increases the activity of the heart tends to exhaust its reserve force. This fact may be considered too obvious to require emphasis, but the converse of the proposition cannot be too frequently repeated, that in all conditions of heart impairment rest is the most important element in the treatment.

Whatever may have been the original cause of any abnormal heart condition, whether valvular lesions, vascular hypertension or acute or chronic disease of other organs, the basic cause of all cardiac insufficiency lies in the heart muscle itself. For instance, valvular lesions should be considered from this standpoint, that they are only one link in the chain of causes of incompetence and that the determination of their exact nature is of importance secondary to the knowledge of the condition of the heart muscle itself.

Viewed from this standpoint, therefore, we can consider the symptoms, the physical signs and the treatment of the failing heart in a general way, without regard to the remote abnormal causes. In fact, in the present state of our knowledge this is the only rational method. In the case of valvular lesions, for instance, the symptoms are not produced by the lesions themselves, but by the acute or gradual failure of the heart to overcome the difficulty. This failure may be produced by the exhaustion of one function or another. Sometimes it is the contractile power and again it may be the tonicity.

If a patient from any cause has a sudden dilatation of the heart his symptoms are so marked and distressing that his attention is drawn to his condition at once. In the gradually

failing heart, however, the first symptoms are more insidious. The patient sometime or another begins to realize that he feels a certain distress or discomfort—it may be only a quickened respiration—on attempting an exertion that before he was able to perform easily. This indicates that the heart is more speedily exhausted than formerly. The physician notes other symptoms, such as pulse and respiration rate out of proportion to the amount of exertion. As the condition progresses other signs and symptoms appear, not only in the heart itself but in the peripheral circulation and in other organs and tissues.

The insufficiency may affect at first only one portion of the heart, and later extend itself over the whole organ. In the former case it is relative; that is the heart is competent to perform certain labors but will not stand the strain of unusual exertion. From this milder form of incompetency there are all gradations down to an inability to keep up the circulation even when the patient is at absolute rest.

While in all cases of advanced decompensation both sides of the heart are affected, the one side often because of the extra burden placed upon it by the primary weakness of the other side, it may make for clearness to describe that affecting one side and its gradual extension to the other.

Weakness of the left ventricle leads to diminished filling of the systemic arteries and afterwards the veins, dilatation of both ventricle and auricle, with engorgement of the pulmonary veins, arteries and capillaries. The velocity of the circulation is lessened, the distribution of the blood modified, and the lung overfilled. This condition throws an enormous extra burden upon the right heart, which must over work in order to pump a blood stream into the already congested lungs. The right ventricle in turn succumbs and finally dilates. This dilatation is caused by its inability to discharge its contents perfectly against the heightened pressure in the lung.

The result is a relative insufficiency of the tricuspid valve, damming up of blood in the right auricle, which in turn dilates, and the forcing back of the blood stream into the venae cavae. There result then sluggish venous circulation and passive congestion of various organs. The symptoms of this latter condition would be, cyanosis engorgement and systolic pulsation of the veins, enlargement of the liver, and pendent oedema. Sometimes there is venous stasis in the medulla, with vaso

constriction, high blood pressure and dyspnoea of medullary origin.

In most cases of weakness of the right ventricle, however, the arterial tension is lowered, even when the left ventricle is comparatively normal. This is due to the fact that the latter cannot propel the proper amount of blood, because it receives less from the lungs.

In such cases the examiner will find a displacement of the apex beat to the left, a more or less increased area of cardiac dullness, both to the right and left, and an enlarged liver. There will be evident also, superficial venous engorgement and, if the tricuspid orifice is increased in size, a positive or systolic venous pulse.

To describe in detail the symptoms caused by the failing heart except in the most superficial manner would be impossible in a paper of this kind. They are in the main, shortness of breath, cough, pendent oedema, decrease of urine usually with the presence of albumin; palpitation, with or without pain radiating from the pericardium down the arms; digestive and hepatic disturbances, and mental abnormalities ranging from nervousness to hallucinations. Two characteristics may be mentioned concerning cardiac dyspnoea. One peculiarity is that it is increased on lying down and relieved by a sitting posture. The reasons for this are, first, that when one is upright the liver and diaphragm descend and allow more air space in the lungs; second, the blood stream is slowed, the volume of returning blood diminished, and the left ventricle is thus enabled to relieve the engorgement of the pulmonary capillaries; third, the venous stasis in the medulla is relieved. Another peculiarity of cardiac dyspnoea is the exacerbation during sleep. In sleep the respiratory centers are less sensitive, respiration is somewhat less frequent and  $\text{CO}_2$  is allowed to accumulate. In this connection it is well to remember that strychnine is of more use than morphine for relief because the former stimulates the respiratory centers. Morphine quiets the distress by deadening the sensibility of the respiratory center which in turn allows the accumulation of  $\text{CO}_2$ .

Cough is a more or less prominent symptom, occurring at one time or another, and especially in later stages is apt to be troublesome and rest-breaking. When dry and hacking it may be caused by engorgement of the sublingual veins, but it is primarily due to a similar condition of the pulmonary vessels



with increased secretion of the bronchial mucus glands. The pressure of a dilated left auricle upon the recurrent laryngeal nerve is a frequent cause. In severe cases, with marked stagnation of blood in the lungs, there is an exudation of the red blood corpuscles into the alveoli, followed by the appearance in the expectoration of the "Herzfehlerzellen." This is usually associated with a chronic interstitial pneumonia and dilatation of the pulmonary capillaries. The brown induration, as it is called, is caused by the deposit of haema siderin in the indurated tissues. Oedema of the feet and legs occurs at some stage of every case of heart disease. In some cases it appears early and in others late, and it does not necessarily indicate a desperate condition. Oedema of cardiac origin differs from that of nephritis in that it occurs where the blood stream is slowest, and hence first in the most dependent portions. Cohnheim showed a number of years ago that an exudate presupposes injury to the vessel wall. In nephritis the blood contains a substance which has a lymphagogue action and hence nephritic oedemas can occur anywhere throughout the body. In heart insufficiency, however, the injurious action is caused by local stasis and the lack of oxygen in the blood. From the feet and legs it progresses upward to the genitalia, the abdominal cavity (ascites) and finally to the chest (hydrothorax). Even in desperate cases rest and proper remedial measures, in restoring the lost heart function, will often cause a disappearance of the fluid. It is usually necessary in marked ascites to remove the fluid by paracentesis because its presence with the consequent pushing up of the diaphragm and also its pressure on the abdominal vessels further embarrasses the heart.

In hydrothorax it is usually the right side of the chest that is affected on account of the position of the azygos vein which drains the intercostal spaces and the pleural. This vein enters the superior vena cava obliquely and hence its mouth is readily closed off. The heart in hydrothorax is usually displaced to the left, by which its action is impeded, and respiration is embarrassed by the presence of fluid surrounding the right lung and the presence upon the left lung by the displaced heart. In all cases of hydrothorax the fluid should be removed by paracentesis. Great care should be taken in this procedure as death has frequently followed its too rapid removal.

As to renal complications, albuminuria and diminished secretion always follow broken compensation, and are due to stasis in the vena cava and renal vein. It is of importance to differentiate between a primary cardiac disease with secondary renal involvement and a primary chronic nephritis with the sequence of an arterio-sclerosis, cardiac hypertrophy and finally a cardiac insufficiency.

In determining this point the phenolsulphonaphthalein test is a great help. If the kidney cells are badly damaged their power of elimination is much impaired.

While palpitation may occur in all heart cases, whether organic or functional, its persistence in an organic case is a cause of great annoyance, not the least element of which is that it reminds the sufferer constantly of his condition. It is often a very stubborn symptom slow to yield. Aside from therapeutic measures for relief may be mentioned the application of cold to the precardium, vibratory massage, and sinusoidal currents.

Precordial pain is by no means a constant symptom. It is frequently present in dilatation of the heart and when there are lesions of the mitral and aortic orifices. It is most prominent in sclerosis of the coronary arteries. For relief of this distressing symptom Sir William Ewart recommends inhalations of CO<sub>2</sub> well diluted with air.

Digestive disturbances such as fermentation with gas formation, constipation, and so forth, are caused by the portal engorgement. In nearly all such cases there is a diminution or absence of HCl and hence considerable benefit is derived by supplying this deficiency.

Concerning the general treatment of heart failure there is so much to be said that it will be possible to touch upon only a few of the most salient points. There is one feature in the handling of every case, without which no hope of a favorable termination should be entertained. Let me call your attention again to the following well recognized, but often forgotten truths:

First. No matter what the nature of the heart condition the immediate cause of heart failure is a loss of the reserve force brought about by its labored efforts to overcome the difficulty.

Second. Any exertion on the part of the patient increases the number of cardiac contractions.

Third. This increase is at the expense of the diastole and hence shortens the period during which it rests and receives nourishment.

The most obvious element in the treatment, then, is rest. This principle is so universally recognized that it may seem superfluous to put stress upon it, and yet how many of us enforce it as we should. Rest may be relative or absolute, depending upon the remaining strength of the heart, but in all cases even of a moderate degree of heart failure, with systemic symptoms the patient should be put to bed and not allowed to place any strain upon that organ whatever.

Rest should be mental as well as physical. Generally speaking, there is no more anxious, restless person than the heart patient. The physician can do much to reassure him about his condition. The best rest is obtained during sleep and it goes without saying that if such a patient passes restless, sleepless nights his recovery is jeopardized. Whatever will encourage or produce sleep, from hot milk to an opiate, in extreme cases, is not only justified but absolutely essential. I have often been called to see patients who had passed many successive nights of agonized sleeplessness. For this condition the bromides are preferable to narcotics.

As bodily comfort is an essential to rest everything should be done not only to relieve pain but to remove every source of discomfort. Many heart patients prefer to sit up as lying down increases the dyspnoea.

As to diet, two or three principles may be laid down. The ingestion of liquids should be limited to about three pints daily. If possible the amount in twenty-four hours should be no more than the total quantity of elimination from the kidneys. Soups and broths usually put more burden on the digestive apparatus than simple, nourishing dry foods that must be chewed thoroughly. I think that we do not sufficiently appreciate the importance of mouth digestion. The quantity of the meals should not be large and the intervals frequent. Salt should be restricted as it has been proved to be a factor in oedema.

Venesection as a means of relief in extreme cases is often practiced. Whether it ever does any permanent good is a mooted question.

It is indicated when there are deep cyanosis, labored breath-



ing, much oedema, especially of the lungs, and the cardiac dullness is greatly increased to the right.

According to Mackenzie, inhalations of oxygen are of great benefit in acute cardiac overstrain, in the spasmodic dyspnoeas of cardio-sclerosis, in cheyne-stokes respiration, and in angina pectoris. The oxygen must be given in concentrated form, as it is useless when much diluted with air.

In speaking of drugs, the subject is of so much importance and the time allotted to this paper so short that I shall content myself with a few generalities. The selection of the homœopathic remedy depends not so much upon the immediate subjective and objective symptoms, as upon the totality, and hence with the exception of half a dozen drugs which seem to be essentially useful in certain heart conditions, the simillimum may be any one of a hundred.

The one drug most frequently associated with the heart in the minds of all of us is digitalis. Digitalis is used by many with so little discrimination that if it were not for tradition and habit I am sure that its frequent failures would soon bring it into disrepute, and yet within its proper sphere it is the most valuable of all the remedies. It may be well to name some of the conditions for which digitalis is not indicated.

In general terms, it is not of use unless there is dilatation. In old rheumatic affections with dilatation it has a beneficial action but without the dilatation it is of little or no effect. Also, in dilatations during acute febrile affections, or when there is advanced cardio-sclerosis and in the rapid heart of phthisis it is of little use.

The most important action of digitalis is its effect upon the function of tonicity. A heart with this function impaired—the dilated heart—never empties itself fully and tries to make up by its frequency for the lack of force in its contractions. If with this condition there is also auricular fibrillation (the “Nodal rhythm” of Mackenzie) its beneficial action is at times marvelous. In the arrhythmia of heart-block, however, digitalis is contra-indicated.

**GALL-STONES.**

BY

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AUTHORITIES agree that pathological and functional derangements causing biliary lithiasis is one of the most common troubles of the human race as well as one of the most interesting subjects in medical study, clinical, pathological, chemical and bacteriological.

Biliary concretions may form in the intra or extra-hepatic ducts, occasionally in the liver, but the gall-bladder is the most common location. They may be all sizes and shapes, solitary, multiple from gravel to calculi large as a walnut, a recorded case notes five inches in length. Multiple calculi are usually faceted, from mutual pressure and of polygonal form. They vary from light yellow to dark greenish black. Solitary calculi have no facets and are irregular in shape.

Gall-stones are largely composed of cholesterin approximating 70 to 80 per cent. Usually combined with the cholesterin are insoluble salts of lime and epithelial debris. Products of lithogenous catarrh of the gall-bladder and ducts, magnesia, fatty acids, biliruben and a trace of iron have been found. Stones of pure cholesterin are very rare and are almost transparent.

A radiograph will verify the presence of gall-stones in those cases having an unusual proportion of lime salts or the calculi have an external shell or coating of lime, which is sufficient to give a differential obstruction to the X-ray; good radiographs are then obtained. As these cases are rather rare, we cannot count on the X-ray as a reliable diagnostic agent.

Age, sex, enteric and intestinal diseases exercise an important influence in the cause of gall-stones. Fifty per cent. occur in persons over forty years; while three fourths of the cases are believed to develop in women, child-bearing forming a direct cause. Naunyn's statistics show ninety per cent. of women with gall-stones have borne children. Fat subjects who take little exercise, heavy eaters who have caused an inharmonious relationship of the internal secretions as well as the secreting glands, sedentary occupations, corsets, enteroptosis and nephroptosis, chronic constipation are all favoring causes

of the hepatic and gastro-intestinal diseases leading to the formation of calculi.

A case from my records, treated a few years ago, illustrates these etiological factors: A lady 42 years of age, married, mother of two children, hearty eater and sedentary by habit, subject for several years previous to digestive disturbances, flatulence, slow digestion making her uncomfortable hours after eating, suspected enteroptosis.

She began suddenly to have attacks of severe epigastric pain, nausea, vomiting, tenderness over the hepatic region, icteru developing after each attack. The seizures becoming frequent and increasing in severity, operation was advised. I then suggested a course of internal medication (having only at this time observed her case during the attacks of colic) with a careful regime in diet and hygiene. Following my suggestion her attacks of colic ceased after two months, none having developed since, or about four years. The calculi in this case were light brown and faceted, and she had a marked high arterial blood pressure, systolic 190 m.m. Chelidonium, china, colocynthis, bryonia and nux vomica were the remedies prescribed during my observation of the case.

Normally, the gall-bladder holds about two ounces of bile; but it has been known to distend so that two pints were contained without rupture. The gall-bladder neck is also very flexible and elastic (which enables considerable sized calculi to pass without rupture) and is continuous with the cystic duct, valves markedly narrow orifice of the neck of the gall-bladder as also the cystic duct, which fusing with the hepatic forms the common duct and empties into the duodenum at Vater's diverticulum, where there is a marked constriction forming a final obstacle to a passing calculus.

In the normal state, the gall-bladder, bile ducts and the bile are aseptic and sterile. The bile, however, is not germicidal or antiseptic, as the various bacilli frequently found in the intestines, such as colibacilli, staphylococci, streptococci and typhoid bacilli have been cultivated in a bile culture medium.

We may conclude from these experiments that angiocholitis, cholecystitis and hepatitis are diseases usually superinduced by bacterial ferments passing from the duodenum through the ducts, infecting and creating inflammatory processes in the ducts and gall-bladder. Calculous cholecystitis, gall-stones and their sequences are the result.



The classic symptoms of hepatic colic, i. e., sudden paroxysmal epigastric pain, nausea and vomiting with chilling, flatulence, tenderness over the liver, sweat with or without rise in temperature is sometimes attended by persistent vertigo lasting days after the attack, and not infrequently ushering it in.

A case within the year typically illustrates this concomitant symptom. Some months ago I was urgently called one evening to attend an old gentleman of 70 years. Found the patient retching and vomiting. Very moderate epigastric pain; tenderness over the liver and in a profuse sweat; pulse weak and thready; no temperature. With these active symptoms he complained of a distressing vertigo increased by every movement. In fact the vertigo alarmed and distressed the patient more than the colic. Although by the following morning the vertigo was markedly improved as well as all active symptoms. The dizziness persisted for a number of days. Bile appeared in the urine and icterus was marked.

This case seems especially interesting in the associated relationship of a distressing vertigo, profuse sweating and prostration, minimum epigastric pain followed by the usual prompt reaction which characterizes hepatic colic when the calculi have passed into the intestine.

In this brief paper the writer will not attempt to enter into comparative detail and differentiating diagnostic sequences emanating and associated with the pylorus, and the first inch or so of the duodenum or their relation and influence in causing inflammatory conditions leading to the formation of calculi.

My desire to testify for old friends in our *Materia Medica* was the inspiration which led to this consideration of gallstones from the objective, of the internist, lest Dryden's plea be forgotten in an age of surgical absorption:

"Medicine is mine; what herbs and simples grow  
In fields and forests, all their power I know."

For we find our most potent remedies for these liver and intestinal disorders are found almost entirely among the flowers and plants of field and forest, and they are frequently curative whether these inflammations are caused by faulty function, lower opsonism or migrating bacteria.

Without giving the clinical indications which are familiar, I will briefly mention the remedies which claim my attention in

gall-stones and their associated disorders, viz.: *Berberis vulgaris*, *bryonia album*, *chelidonium*, *chionanthus*, *china*, *colocynthis*, *chamomilla*, *chenopodium*, *dioscorea*, *eupatorium perfoliatum*, *euonymus*, *hydrastis*, *juglans*, *cinera*, *laurocerasus*, *nux vomica*, *podophyllum* and *veratrum album*. Supplemented by *arsenicum alb.*, *cuprum*, *calcareo carbonica*, *kali bichromate* and *aurum*.

*Berberis*, *chelidonium*, *chionanthus*, *china*, *juglans*, *nux* and *podophyllum* are, in my experience, more frequently indicated.

Naturally the line of treatment of a case of hepatic calculi is governed by the condition of our patient under observation. During an active colic the first necessity is to apply such measures that the patient may be relieved from suffering which is usually very severe and at the same time facilitate the expulsion of the calculi from the duct into the bowel.

We may have here indicated one of several remedies, e. g., *berberis*, *belladonna*, *colocynthis*, *chamomilla*, *dioscorea* or *nux*. If relief is not obtained promptly from the selected remedy, it may be necessary to relax and relieve the pain with *morphia* hypodermically, which may be supplemented by an occasional whiff of chloroform.

I have found chloroform internally gives excellent results at times by dissolving ten drops in one half glass of water, giving teaspoonful doses at frequent intervals. In cases where the calculi is slow in passing, aspirin may be recommended at intervals in five-grain doses. An enema of chloral hydrate also has its advocates.

Warm flannel moistened in equal parts of chloroform and olive oil and placed over the hepatic region is usually very grateful. Turpentine stupes may be substituted when the above is not available.

During the intervals between migrations of calculi, active prophylactic and curative treatment should be carefully instituted. The diet should be free from fatty foods, excessive amounts of sweets and sugars, fermented acids, vinegars and alcoholics; citric acid fruits in moderation, the juice of a lemon dissolved in a glass of water and taken at bed time is an excellent alterative for some cases.

Tight clothing in corsets and waistbands restricting the abdomen should be discarded. So far as possible the clothing had best be suspended from the shoulders.

Moderate exercise in the open air should be advised—walking, riding, rowing, golf, etc.

These cases should be instructed to drink plenty of water to promote increased eliminative activity, occasionally a natural aperient water will be beneficial, such as Vichy, Carlsbad or Bedford waters. A sojourn to either of these springs may prove a welcome change for some of these patients.

The general trend of opinion for surgical intervention when gall-stones are found is much more daring in this country than abroad, where more conservative treatment is usually followed.

Repeated attacks of gall-stone colic growing more frequent and severe with an increasing disturbance in the gastric and hepatic functions even under the administration of our carefully selected remedies supplemented with the proper diet and hygiene, naturally indicates that the patient may be in safer hands with the surgeon, calculous cholecystitis, a stone permanently lodged in the common duct or a fistulous opening in the gall-bladder or ducts, are illustrations for surgical intervention. Not infrequently however if a patient had early received the needed treatment and been advised and followed a hygienic regime, such extreme pathological development would more rarely occur.

The very favorable statistics of operation by the surgeon are based on the immediate results of operative methods rather than the subsequent history of these cases. Mayo brothers' mortality for all operations on the gall-bladder and ducts (not malignant) is reported at less than three per cent.

In closing I am selecting from my files a case which was of unusual interest to me and proved a classic illustration of a catarrhal cholecystitis with gall-stones and duodenal irritation, and whose recovery was a great gratification to the writer.

During the night of February 11, 1912, I was called to attend a lady of sixty-three years of age, suffering acutely from gall-stone colic, severe griping pain through the epigastric region, tenderness over the liver, bilious vomiting with sudden onset. Next day the patient was weak and prostrated and the skin markedly icteric. This is a brief description typical of a number of succeeding experiences with this case.

A history of having had similar attacks at intervals for several years and although under treatment most of the time her



attacks of colic were steadily increasing in severity and frequency, varying from three to six weeks with discouraging persistency. After attacks of colic dark bluish-black calculi were passed with stools. Urine containing bile and marked jaundice accompanied each aggravation. In fact the skin was never clear, having a bronzing appearance.

Chionanthus, juglans, hydrastis, china and nux were the remedies chiefly prescribed for this patient. Improvement at first was slow. Her strength and activity gradually returned with her gain in appetite and digestion. August 6, 1912, dates her last attack of colic. Her skin cleared and is quite fresh and healthy in appearance, the patient looking younger, and reports feeling so in mind and body.

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#### DERMATITIS SEBORRHOEICA----ITS MODERN CONCEPTION, DIAGNOSIS AND TREATMENT.

BY

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DERMATITIS seborrhoeica is caused by a definite micro-organism—the micro-bacillus of seborrhoea—which usually has co-associated with it the bottle bacillus of Unna. Therefore, it is a disease of definite entity, which will help materially in a differential diagnosis.

It is characterized by the presence of yellowish, greasy scales surmounted on an inflammatory base. The presence of oil or grease in these scales can be easily demonstrated by placing them upon a clean white piece of blotting paper, the paper taking up the grease and leaving an oily spot thereon.

The subjective symptoms are mild, itching being very slight, which is very much aggravated by the presence of heat.

The sites of predilection are the scalp, forehead, commissures of the nose, sternal, interscapular region, axilla and groin.

Dermatitis seborrhoeica may be confused with eczema, pityriasis rosea and papulo-squamous syphilides. However, it can readily be differentiated from eczema, especially as it has been pointed out so ably by my worthy teacher and clinical chief, Dr. Ralph Bernstein, that eczema is a disease without a definite entity; whereas the micro-bacillus of seborrhoea being the causal

factor of seborrhoea dermatitis, it therefore does have a definite entity. This can be quickly and easily demonstrated by placing a smear upon a glass slide, washing with alcohol and ether, covering with methylene blue, allowing the stain to stand from five to ten minutes, and there will thus be revealed myriads of micro-bacilli, and here and there a few bottle bacilli of Unna; thus immediately establishing the definiteness of entity of this disease.

Seborrhoeic dermatitis must not be confounded with the simple type of seborrhoea, such as seborrhoea oleosa and seborrhoea sicca. These types, however, may co-exist with dermatitis seborrhoeica. The condition can, however, only be presumed to be dermatitis when we once have a definite inflammatory reaction established.

There are certain types of psoriasis which have a co-associated seborrhoeic element predominating, and may then be known as seborrhoeic or super-seborrhoeic psoriasis. People who are prone to attacks of seborrhoea or seborrhoeic dermatitis are usually subject to attacks of acne and comedo, as they usually go hand in hand together.

In a differential diagnosis from pityriasis rosea, which at times is very difficult to make, if one will bear in mind that frequently pityriasis rosea may have its onset characterized by the presence of a mother spot—a single lesion somewhere on the body which precedes the onset of the generalized eruption for from a week to ten days—it will be an easy matter. The lesions of pityriasis rosea are ovoid, clear centered, usually roseate in color, with fine, branny, desquamative scales, which however are not greasy. The lesions of pityriasis rosea have a marked tendency to want to follow the cleavage of the lines of the ribs, and thus frequently stand out very prominently.

In generalized eruptions of seborrhoeic dermatitis it is also hard at times to diagnose from papulo-squamous syphilides. Here again, the scales in the syphilides are not greasy. The eruption is more apt to be generalized, even including the palms of the hands and soles of the feet, which is not so in seborrhoeic dermatitis. There may and may not be a history of syphilis to assist in the diagnosis.

With reference to the local treatment of seborrhoeic dermatitis, naturally, the disease being a micro-organic one, all that one has to do is to bear in mind Dr. Bernstein's clinical subdivision of skin diseases, that is, as to whether the disease is

micro-organic or non-micro-organic in character. Since this disease is micro-organic in character, following the plan laid down by Dr. Bernstein, the logical thing to do then would be to use a parasiticide, or something to combat the activity of the micro-organisms at work.

Sulphur and resorcin in combination are the ideal antagonists of the micro-bacillus of seborrhoea, usually in amounts of twenty to thirty grains to the ounce of ointment base; to be thoroughly rubbed in night and morning, and to be continued for a long time even after the apparent disappearance of the condition, because the disease is a decidedly hard one to eradicate and shows a marked tendency to return.

Where an ointment is not preferred, the lotio alba or the compound zinc sulphide lotion may be used, which is made up of a half drachm each of zinc sulphate and potassium sulphide to six ounces of rose water.

The indicated remedy is of great service in the treatment of this condition. Among the more important remedies are sulphur, natrum muriaticum, nitric acid, calcarea carb., agaricus and sepia.

DIAGNOSIS AND TREATMENT OF FRACTURE INVOLVING THE KNEE-JOINT.—John Baptist Blake, Boston. *Annals of Surgery*, July, 1913. The five principal traumatic bone lesions involving directly or indirectly the knee are influenced less than might be expected by the fact that they invade the largest joint in the body.

Trauma affecting the knee-joint, if sufficient to produce fracture, causes fracture of patella most frequently, of femur next in order, and of tibia least often: in patients under 20 years such trauma usually causes separation of the lower femoral epiphysis.

With the exception of sepsis, the other complications added to fractures in this region are: a. Greater difficulty in maintaining position of fragments; b. greater limitation of motion after union has taken place; c. in certain operative cases, an added danger, that of invading a joint with a solid body.

The indications for treatment are similar to those applicable to other fractures except that non-absorbable materials should not be used within the limits of the knee-joint unless it is absolutely unavoidable, and the immobilization be practiced for a period longer than is advisable in fractures not involving joint cavities.



## Transactions of the New Jersey State Homoeopathic Medical Society.

### HAHNEMANN'S DISCOVERIES IN THE LIGHT OF TWENTIETH CENTURY MEDICINE.

BY

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IN my remarks to-day, I shall not dwell at length upon the many discoveries and betterments made by Hahnemann in the field of chemistry and physics, such as his concise and excellent method of testing the purity of drugs, the accuracy and refinement of which would lead one to think of the laboratory work of to-day, rather than that of a century and more ago; his discovery of a soluble form of mercury, of which Prof. Gren said, "The problem of securing a preparation of mercury which is at once soluble and yet free from corrosive properties, is fully solved by Hahnemann's *mercurius solubilis*"; his improved method of refining saltpetre; his test for metals, more commonly known as his "wine test," the principles of which are still utilized in our laboratories; and in fact a score and more equally important discoveries in the field of chemistry; nor shall I dwell upon the evidence of his profound knowledge of chemistry, physics and the collateral sciences as shown in his *Apothekerlexicon*, every page of which bears witness to his brilliant attainments; nor quote his advanced views upon hygiene and sanitation, although each of these subjects would afford fruitful topics for interesting review and study. Rather let us center our thoughts upon what Hahnemann accomplished in the domain of pure medicine; especially those revolutionizing discoveries which he brought to such perfection, and transmitted in their integrity an inheritance to the profession.

Among the most important of these, and chronologically first, we must note his development of the systematic proving of drugs upon the healthy human subject, as a prerequisite to their therapeutic use.

Hahnemann, whose first purposeful experiment in drug

proving occurred probably in 1790, with the cinchona bark, does not claim originality for the idea. In the foot-note to section 108, of the *Organon* he distinctly says: "Before me Haller alone conceived the necessity of pursuing such a course." But, in the method of its development and richness in results, originality surely belongs to Hahnemann.

This richness in results is no longer confined to that great storehouse of provings, "the *materia medica pura*," but gradually has invaded the work of the whole profession. The so-called physiologic provings, many of which have been made upon man, have added much useful information. Unfortunately, however, the dose employed has, as a rule, been so large, that the finer distinctions developed under the Hahnemannian method are not elicited.

Although these cruder experiments have but little value as guides to the selection of the therapeutic agent for the concrete case of disease, they nevertheless throw much light upon the grosser effects, and point to the physiologic range of its action, thus roughly showing its possible therapeutic sphere.

In 1796, Hahnemann published, in Hufeland's *Journal*, "An Essay on a New Principle for discovering the curative power of drugs." Therein he first presented his views upon the three modes of drug action, and declared in favor of "employing in the disease we wish to cure that medicine which is able to produce another very similar artificial disease, *similia similibus*."

In his essay, "Medicine of Experience," published in 1805, Hahnemann elaborated upon this thought; and in the *Organon*, the first edition of which appeared in 1810, we find a very full exposition of his views regarding the entire field of what rightly constitutes "Institutes of Medicine."

The foundation upon which all of Hahnemann's work was based rests upon the bed-rock of demonstrable facts. "Pure experience is the only infallible oracle in the healing art," says Hahnemann in section 25 of the *Organon*. He further explains that such experience can be gained only through the comprehensive and accurate observation of facts, in conjunction with their critical analysis, systematic correlation and subsequent reference to definite law.

What a contrast this presents to the then universal, and unfortunately still too common method of crude empiricism.

Mackenzie expresses this thought tersely yet pungently in the following words: "The sister sciences in place of seeking

assistance from medicine, look askance at the wild speculations put forth in the name of medical science and at the loose thinking and play of the imagination which many medical writers deem legitimate in dealing with the phenomena of disease."

While Hahnemann's method of accurately ascertaining the field of action of each drug through its symptomatology, has been derided by the opponents of homœopathy, a review of their work proves that they have signally failed to offer any worthy substitute. Their arguments prove that they have neither comprehended Hahnemann's philosophy nor understood his method. Charging Hahnemann with advocating the treatment of single symptoms instead of the entire complex manifest in the individual patient, they either wantonly or ignorantly have perverted the truth. Thus in Wood's *Therapeutics* we find the following criticism: "The childish absurdity of treating symptoms by any such law as *similia similibus curantur* or *dissimilia dissimilibus curantur*, is at once apparent. The same symptom may be the result of absolutely antagonistic conditions and require absolutely opposite treatment." All of which proves that the writer was grossly ignorant of Hahnemann's teachings.

To properly comprehend Hahnemann's conception of the symptomatic picture of a given case of disease we must carefully study the *Organon*. Thus in Section 6, he says: "An unbiased observer, though of unequalled astuteness, impressed with the futility of transcendental speculation unsupported by experience, observes in each individual disease only what is outwardly discernible through the senses, namely, changes in the state of the health of the body and mind, morbid signs or symptoms. In other words he observes deviations from the previous healthy condition of the patient felt by the patient, recognized upon him by his attendants, and observed upon him by his physician. All these observable signs together, represent the disease to its full extent, that is, they constitute the true and only conceivable form of the disease."

In Section 7, he explains further that, "In a disease presenting no manifest exciting or maintaining cause (cause occasionalis) for removal, nothing is to be discerned but symptoms." While in Section 18, he declares: "From this incontrovertible truth, that beyond the totality of the symptoms there is nothing discoverable in diseases whereby they could express their need of a remedy, it undeniably follows that the



totality of symptoms observable in each case of disease, can be the only indication, the only guide to the selection of a remedy."

Logically and scientifically speaking we should rather assert that it would not only be worse than "childish" it would be criminal for the physician to fail to consider every symptom and carefully appraise both its diagnostic and therapeutic value.

I am pleased to note that more recent writers emphasize the importance of such symptom pictures, a fact that surely will contribute largely to the advantage of the patient and redound to the credit of the profession. They also have begun to recognize the fact that when a diagnosis is obscure, owing to contradictory symptoms we, both logically and practically, have the advantage in prescribing. May we not hope for their greater enlightenment in the near future?

The characteristic individuality of each drug, its symptomatic picture or pathogenesis, is now commonly recognized. It is also equally well known that many active toxic agents widely differing in origin, will when tested in large doses, present marked similarity in their effects. Thus, if we compare the effects of antimony, arsenic, copper, veratrum, cholera, typhus and other infections, we will find the following symptoms in each: Rapid loss of strength, abdominal discomfort and pain, scanty urine, diarrhœic stools, rapid and labored respiration, rapid and weak pulse, decreased surface temperature with high rectal temperature, coma, convulsions and even death. Yet I scarcely need assert that a knowledge of such crude facts will do but little to advance either the science of pathology or therapeutics, being equally unsuited to each.

Hahnemann taught that each remedy manifests a specific sphere of action, differing in some essential from every other remedy: a principle that is gradually being acknowledged by advanced thinkers in every school of medicine.

Again, the acceptance of the dual action of drugs as a demonstrated fact, has done much to bring the profession in closer harmony; especially, since it has been proved that this dual action is dependent upon the quantitative dose employed.

This phenomenon of drug action long caused doubt in the minds of many practitioners. The query naturally arose: How can symptoms and conditions so opposite in character possibly depend upon the action of the same drug? This long remained an unsolved problem, but thanks to the indefatigable labor of Dr. Charles E. deM. Sajous, we are able to give a satisfactory

and scientific explanation of this natural phenomenon. With many remedies it is readily explained; with all it is discoverable. To illustrate I will cite our well known polychrest belladonna, the provings of which are replete with such opposite or antithetical symptoms, such as: memory active and retentive, and its opposite forgetfulness; talkative then mute; photophobia, photomania; hearing sensitive, or deafness, as if a skin were drawn over the ears; sense of smell acute, or, sense of smell lost; face flushed and hot, or, face pale and cold; and many others.

That these opposite conditions are attributable to the action of the belladonna, is clearly evidenced in the recorded provings, and although apparently paradoxical, they, when properly interpreted become most valuable therapeutic indications in various forms of disease.

In order to understand how a given drug may produce such opposite effects, we will consider for a few moments the influence of large and small doses of this remedy upon the pituitary body and the organs under its physiologic control.

We now know that the anterior and posterior pituitary bodies are the general centers that actively sustain cellular metabolism. The anterior pituitary body insures oxygenation of the blood and all oxidation processes. The posterior pituitary body adjusts the vibratory rhythm of all nervous impulses which incite and govern functional activity, consequently they jointly govern to a large degree the control of all toxic waste products, the elimination of which is so largely a process of oxidation.

To define this relationship briefly, permit me to call attention to a few of the most salient features of this process. The pituitary body is composed of two lobes, an anterior or glandular lobe and a posterior or neural lobe. Imbedded in the partition between these two lobes, is a structure bearing a striking analogy to the osphradium or test organ of mollusks and other invertebrates, an early prototype of the pituitary body.

The pituitary with its test organ constitutes an organ of special sense, protecting the body against the harmful effects of poisons of all kinds. The test organ, readily excited by the presence of any form of toxic substance in the blood, activates the anterior pituitary which in turn stimulates the adrenals to greater activity, thus increasing their secretion; which is carried into the blood by way of the suprarenal veins to the vena

cava. Converted into adrenoxidase, in the lungs, it reaches the general circulation and excites the spleno-pancreatic secretions thus increasing the amount of trypsin in the circulating fluids and in the tissues. To this substance, trypsin, we must attribute "the main prophylactic function, namely, that of a proteolytic ferment capable of reducing bacterial toxins, toxalbumins, vegetable poisons and venoms."

The action of belladonna upon the anterior pituitary affords a physiologic interpretation of many of the symptoms observed in our provings, and lifts the veil of obscurity that has clouded the many antithetical symptoms found therein. It is demonstrable that a given dose will produce certain definite results through stimulation of the pituitary, whereas a larger dose or frequent repetition of smaller doses will result in depression, thereby producing the antithetical symptoms referred to.

Thus we find the most recent physiologic facts confirm Hahnemann's provings, even to the point of clarifying the obscure and often doubted opposite symptoms occurring in so many of the pathogeneses of our remedies.

Further, we can utilize the knowledge thus gained to the advantage of our patients and the more scientific development of our posology. In the more commonly characteristic belladonna patient the symptoms are indicative of the stage of initial stimulation of the adrenals, here potencies from the sixth upward will prove most serviceable; whereas if the symptoms of depression, such as pale face, weak and irregular pulse, shallow and irregular respiration predominate,—a condition observed in many cases of alcoholism, the lower potencies or even small doses of the tincture will be preferable. Watchful care, however, must be exercised in repeating the dose, else ill effects may result.

Here again, the twentieth century has brought to light many facts which prove the correctness of Hahnemann's teachings in regard to the repetition of the dose. Experience with tuberculin has proved that repetition before the opsonic index begins to recede from its high point, which is usually between the seventh and twenty-first day after administration, will produce injurious results. Thus after a century of empiricism, investigators are adopting the Hahnemannian view.

A word in regard to the law of similars, which I may say, has unwittingly been permitted to invade the practice of the dominant school until to-day it is an accepted method of pre-



scribing by many of its practitioners. In addition to the drugs, such as the aconite and belladonna in their characteristic fevers; bryonia and rhus in rheumatic affections; calcarea sulph., in suppurative processes; pulsatilla in amenorrhœa; nux vomica in digestive disorders; ipecacuanha in vomiting, all being prescribed upon well recognized homœopathic indications, we find the law of similars trenched upon in the use of the nosodes, such as constitute the various serums, vaccines and phylacogens. In the latter the similarity is brought to such a degree that autogenous vaccines and phylacogens (because of the exact similarity of the infecting bacteria and their toxins) are especially recommended. Could anything be more gratifying to the advocate of genuine homœopathy?

Remember, these so-called Isopathic remedies were introduced during the early days of homœopathy; were denounced in unmeasured terms by our opponents but gained some of our greatest triumphs; I need but mention anthracin to prove this assertion.

Hahnemann thought them of sufficient worth to allude to them in a footnote to Section 56, of the Organon, in the following words: "Some are seeking a fourth method of applying remedies against disease by means of Isopathy as it has been called—that is applying the causative miasm of a disease against the disease itself. But even if this were possible, and it would indeed be worthy of being called a valuable discovery, the cure could only be accomplished through the highly potentized and thereby changed condition in which the preparation would be administered, consequently only through the opposition of the simillimum against the simillimo."

Our friends, who in the name of pure homœopathy strive to oppose the use of such remedies should weigh carefully Hahnemann's words, and seek to develop the use of these nosodes along truly homœopathic lines.

When we recall the good results secured by Burnett with his tuberculinum which was practically a mixed nosode similar to the phylacogens, and compare with the frequent failure to secure favorable action from pure cultures of the bacillus tuberculosis, we are led to the conclusion that his better results were attributable to the fact that his preparation was more nearly the simillimum of the average cases treated.

Confirmation of this view may be found in the many experiments made during the past few years with the "modified bac-

terial derivatives" of Dr. A. F. Schafer of California, who being convinced that practically all infections were multiple in character, i. e., "mixed infections" and that the pure cultures of any one strain would not reach every case in any given disease, he introduced the use of the mixed infection vaccines,—another illustration of the fact that experience continues to point toward the simillimum for the real curative agents.

Hahnemann's development of a practical materia medica based upon the proved effects of drugs, has resulted in marked advance toward accuracy and scientific certainty, in the work of investigators along corresponding lines in all schools of medicine. Speculative fancies are no longer received with favor; crude empiricism is giving place to scientific methods; hypotheses are being supplanted by demonstrated and correlated facts; the dual action of drugs has been proven a verity and its dependence upon the size of the dose established beyond question.

*Similia similibus curentur*, though still denied place as a therapeutic law, is steadily encroaching upon all other methods of drug therapeutics, so that serums, vaccines and drugs, each are being employed according to this principle by the opponents of homœopathy, and the results in practice are being lauded enthusiastically. Prejudice, however, has so blinded them that seeing, they cannot perceive, and knowing, they cannot understand.

We must further note that these results have followed upon the use of infinitesimals, after failure of the grosser doses. In fact the principles enunciated by Hahnemann have steadily gained ground, asserting themselves in every advance attained in therapeutics. As science has progressed Hahnemann's teachings have proved their rightful claim to recognition and adoption.

With all this the question constantly arises: How can the small doses employed by Hahnemann act? To this, science, independent of medicine is giving answer.

Time was, when the atom controlled our views of the ultimate divisibility of matter; to-day, we know that the dynamic action of matter lies in a region beyond its mere atomic constitution.

Prof. W. H. Bragg, of Leeds University, England, in dwelling upon the kinetic theory of gases and its newer developments, has shown that this older system rests upon another,

which has been forced upon us by the phenomena of radioactivity. He points out that on this system is superposed a more minute system whose infinitesimally smaller particles penetrate in all directions at high speed the very atoms of matter.

These investigations into the constitution of matter, date back to Sir William Crooke's discovery of the ultra-gaseous or fourth state of matter, which Prof. Bragg looks upon as extra-chemical, the movements of its particles being in no way influenced by the combinations of the atoms with which it comes in contact.

It may be interesting to note Prof. Crooke's words in reference to this higher state of matter, in a lecture before the British Association, at Sheffield, August 22d, 1879. "We have actually touched the border land where matter and energy seem to merge into one another, the shadowy realm between known and unknown which for me has always had peculiar temptations. I venture to think that the greatest scientific problems of the future will find their solution in this border land and even beyond; here, it seems to me, lie ultimate realities, subtle, far-reaching, wonderful."

The prophetic feeling here expressed has to a large degree been realized in the developments of science during the past two decades. Independent of therapeutic experiences with the infinitesimal doses of the nosodes, physiology has given us much food for reflection. Take for instance, Morat's experiment with a nerve-muscle preparation of the gastrocnemius of a frog. Stimulated by a definite quantity of energy which may be compared with the energy expended by the muscle, he found the dynamic increase extremely great. He says: "Let the energy supplied to the nerve by a condenser be less than 0.001 Erg, and we will find the energy expended by the muscles to raise a weight of 200 grammes 0.5 of a centimeter, equals 100 grammes-centimeters, which makes 100,000 Ergs (one hundred thousand Ergs.) According to Weiss who has worked out the elements of this calculation the ratio of work produced to work expended is 100,000,000. In other words, the recuperative energy is 100,000,000 times greater than the energy supplied to the small system experimented on." In addition to which we must remember that the mechanical work of the muscle represents but a fraction of the total energy, a considerable portion being carried off as heat, hence the ratio must be still much greater.



Hahnemann refers to the development of increased energy through the process of trituration or dilution with strong succussion, which latter he says is a species of trituration of the liquid, as a true dynamization or awakening of force inherent, but otherwise dormant, in the crude drug substance. In this he but anticipated the latest revelations relative to the constitution of matter, which though interesting we have not time to dwell upon on this occasion.

One more thought and I shall conclude this already too lengthy paper. Hahnemann's psora theory has been the stumbling block to many an investigator of homoeopathy. How could the vast array of symptoms recorded as evidence of the psoric miasm be dependent upon any one cause; and that, such an one as Hahnemann suggested? This was indeed a serious problem, one which caused many doubts even among those who believed in the law of similars. But here again, as physiology has advanced, we find Hahnemann's teachings in strict conformity with its latest revelations.

As already suggested Sajous has shown that the autoprotective organism is constituted of the pituitary, adrenals, thyroid and parathyroids; that any failure in either of these secretions leaves the body to that degree exposed to the various forms of infections. In other words, the autoprotective power of the body depends upon the normal development of the functional activity of these several organs. In the final analysis of the facts as given by Sajous we find: that the secretion of the adrenals, adrenoxidase, represents Ehrlich's amboceptor; that of the pancreas, trypsin, Ehrlich's complement; that of the spleen and leucocytes the nucleo-proteid; and that of the thyroid and parathyroids, thyroidase, Wright's opsonins. Any increase of these secretions enhances the bacteriolytic and antitoxic properties of the blood and phagocytes; whereas a decrease in any element of the protective mechanism must necessarily reduce systemic resistance and render the patient more susceptible to disease influences. Fassin, Stepanoff, Marbe and others have confirmed the correctness of Sajous' deductions. Proof of these facts, however is found not only in the laboratory, but is fully revealed on analysis of the symptoms dependent upon a paucity of these secretions. This is especially noticeable in conditions characterized by hypothyroidia. In making an analysis of the symptoms of this condition, I was much impressed with their remarkable similarity to those given by Hahnemann as indicative of psora.

A critical comparison of these two symptom pictures, and a careful study of the underlying lack of resistance to morbid impressions, leads one to the conclusion that they represent, one and the same condition. The suppression of the external manifestations of any form of infectious eruptive disease will no doubt as Hahnemann observed reduce the activity of the autoprotective system.

The depraved constitutional condition known as psora represents a chronic state of faulty functioning of one or more factors of the autoprotective process, and in its symptomatology corresponds to conditions which we know to be dependent upon hypothyroidia and its physiologic sequences hypoadrenia, etc.

In order to vividly portray the parallelism referred to, permit me to present in comparison some of the symptoms of psora, as recorded by Hahnemann in his chronic diseases, and the symptoms of hypothyroidia as given by Sajous in his work on "The Internal Secretions and the Principles of Medicine."

#### HYPOTHYROIDIA.

1. Mind obtuse: inability to grasp the finer points of an argument, or of a question treated in the abstract.

2. Slow Mental development.

3. Uncontrollable sadness.

4. Melancholia.

5. Maniacal excitement.

6. Delirium.

7. Pain in the occiput.

8. Migraine.

9. Old look. Hair prematurely gray. Hair falling out in patches from the forehead and median line, later from the occiput. Hair may be coarse and brittle. Eyebrows grow thin at the outer end (eyebrows shorten).

10. Skin of the face hard to the touch as in myxœdema, color waxy. May have reddish patch below each cheekbone.

#### PSORA.

Inability to think or perform mental labor properly. Cannot control her thoughts.

Sadness awakens from sleep, at night, with palpitation and anxiety. Tearful mood, weeps for hours without any known cause.

Melancholia.

Mania. Suicidal mania.

Pain ascending from the nape of the neck to the occiput, sometimes over the whole head. Headache worse in the morning on awaking, or in the afternoon during a rapid walk or from loud talking.

Semilateral headache. Tic douloureux.

Old look. Falling out of the hair, mostly in front, on the crown and vertex. Dryness of the hair. Scalp very scaly.

Face yellowish or grayish. Skin may be dry, rough, withered; harsh to the feel

11. Teeth, especially the molars loosen and decay early.

12. Prone to formation of tartar on the teeth.

13. Gums bleed easily and recede from the teeth.

14. Hallucinations of sight, as of small animals, etc.

15. Hallucinations of hearing, as of running water; rumbling noises; tinnitus.

Due to loss of vascular tone and imperfect circulation in the sensory organs.

16. Nasal voice, or husky through infiltration of the laryngeal mucosa.

17. Naso-pharyngeal mucous membrane swollen.

18. Tonsils liable to acute inflammation.

Owing to local accumulation of germs.

Deficiency of germicidal activity, phagocytic and humoral, manifests itself where protection is usually active, namely, along the mucous surfaces.

19. Dyspnœa, especially on going up stairs, or on continued speaking.

20. Palpitation (sometimes with pain).

21. Heart dilated, weak systole, occasional murmurs.

The symptoms of heart and circulation are all traceable to impairment of oxidation and nutrition, the cardiac and vascular muscles suffering therefrom. The blood forming organs being also inadequately nourished anemia results, the erythrocytes are reduced to 3,000,000 or less with more or less anisocytosis. Hæmoglobin may be considerably decreased.

22. Blood pressure low.

23. Pulse weak and rapid.

24. Liver passively congested and enlarged.

Due to low vascular tension, which also explains the occurrence of varicose veins, varicocele, etc.

25. Biliary calculi.

26. Constipation, due to deficient peristalsis. Impaction.

Teeth become loose and decay. Owing to deficient calcium and phosphorus metabolism which deficient thyro-parathyroid secretion entails.

Gums recede from the teeth and bleed easily. Teeth become loose.

Hallucinations of sight, as of flies, etc.

Hallucinations of hearing, as of rushing wind; rumbling; singing; buzzing; chirping, etc.

Hoarseness after the least talking. Hoarseness, also aphonia after a slight cold.

Nasal catarrh after the least exposure to air.

Frequent inflammation of the throat with swelling of the pharyngeal walls. Swelling of the parotid glands—of the submaxillary glands—cervical glands.

Dyspnœa from motion, with or without cough;—from ascending even a slight incline. Suffocative attacks after midnight.

Palpitation with anxiety.

Heart diseases.

Inflammation of the liver. Tension and pressure in the right hypochondrium, impeding respiration and causing anxiety. Pain in the liver from touching the right side of the abdomen.

Constipation; stool retarded many days. Stool hard, as if burnt.



27. Urine high colored and scanty, occasionally containing albumen, casts, sugar or blood.

Renal calculi.

28. Impotence.

29. Loss of sexual desire.

30. Spermatorrhœa.

31. Prostatic hypertrophy.

32. Retroflexion.

33. Amenorrhœa is common but owing to low vascular tone particularly of the arterioles metrorrhagia may occur.

34. Severe lumbo-sacral pains with menstruation.

The pains are due to deficient catabolic activity, the blood becomes laden with toxic waste products.

35. Deep seated pain between the scapulæ.

36. Coccygodynia.

37. Neuralgias.

38. Pains worse from rest in bed.

Rest slows the oxidation process thus increasing the catabolic torpor, and consequently aggravates the pains. Activity within limits increases oxidation and consequently ameliorates pain.

39. Hands flabby and damp.

40. Weakness of the knees.

41. Fibrillary motion of the muscles and trembling.

42. Flat-foot.

May be due to relaxed interosseous muscular and ligamentous support.

43. Languid, fatigued, somnolent on rising, better as the day wears on.

Urine dark, of strong penetrating odor and quickly depositing a sediment. Red sandy sediment at times.

Bloody urine. Pale sweet smelling and tasting urine in large quantities, accompanied by loss of strength and flesh; also great thirst. (Diabetes.)

Loss of sexual power.

Loss of sexual desire (in both sexes).

Nightly emissions.

Induration and hypertrophy of the prostate.

Sterility without discoverable cause.

Menstruation delayed until the fifteenth or later years; or after appearing one or more times ceases again for months or even years. Metrorrhagia accompanied with much pain in the chest and abdomen and numberless nervous symptoms.

Severe pains in the lumbar, dorsal and cervical regions.

Pressive pain between the scapulæ.

Neuralgic pains in various parts.

Many symptoms worse at night, pains, cough, toothache, etc.

Cold hands, or perspiration on the palms.

Coldness of single parts.

While walking in the open air, sudden attacks of weakness, especially of the legs. Sudden bending of the knees.

Sudden twitching of single muscles or limbs.

Attacks of trembling of the limbs. This also applies to increased tendency to strain or over-lift oneself.

The joints are easily sprained.

In the morning on awaking feels stupid, languid; more unrefreshed and tired than on retiring at night.

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| <p>44. Temperature low, complains of feeling cold especially the extremities.</p> <p>45. Rigidity.</p> <p>46. Convulsions.</p> <p>47. Imperfect bony development, pigeon breast, narrow chest.</p> | <p>Every evening chilliness with blueness of the nails.</p> <p>Tonic contraction of the flexors.</p> <p>Convulsions. Epilepsy. Chorea.</p> <p>Softening of the bones. Curvature of the spine. Curvature of the long bones. Rhachitis. Fragilitas ossium.</p> |
| <p>48. Disposition to caries.</p>  | <p>Swelling and ulceration of the humerus, the femur, the tibia, also of the fingers and toes.</p>   |

A critical review of the remaining symptoms enumerated by Hahnemann as indicative of the psoric miasm will lend added emphasis to the physiologic interpretation which is here presented.

When we contemplate the marvelous prescience with which Hahnemann was endowed, we may well say with Professor Eschmayer of Tübingen: "So much has been achieved that we can only gaze with admiration at this gigantic intellect who conceived the idea of reforming medicine, and showed by example how it was to be done."

Thus in the progress of time we find that the truths presented in the philosophy of Hahnemann have been corroborated, not, I regret to say, through the researches of those who have been contented to rest our claim upon the clinical evidence of a century, but by those who in striving after knowledge by the aid of laboratory methods, unguided by Hahnemann's teachings, have through the unavoidable deductions from their researches been rendered active and efficient instruments for the establishment of every principle advanced by Hahnemann.

Time and effort still will be needed to fully develop the wide encircling truths recorded in the *Organon* and the *Chronic Diseases*; rich fields for investigation and research still afford brilliant opportunity for ambitious workers; much still must be done to remove the tares from the wheat of our *materia medica*; a more comprehensive treatment of the provings for the purpose of clarifying the meaning of many obscure symptoms also is needed; and, posology, that vexing subject that has caused so much dissension, offers inviting opportunity for further developmental research.

The law of similars, however, has been confirmed through so many and trustworthy sources that we may rest assured it will ever remain an integral principle underlying medical therapeutics.

**DIETETIC TREATMENT OF SUMMER DIARRHŒA.**

BY

REUEL A. BENSON, M. D.

IN the past ten years the treatment of diarrhœal diseases especially in our large cities has focused the attention not only of physicians but of social workers and philanthropists. As a result there has been a steady decrease in the death rate from these diseases. New York City alone had 466 less deaths from diarrhœal diseases in 1912 than in 1911, and in other cities where similar campaigns have been carried on the decrease has been even greater.

Since 1908 I have had the privilege of sharing in this campaign through the Babies' Dairies, practical feeding stations for sick infants, located in the congested parts of New York City.

During this period of time we have had the opportunity of observing and studying infants under a year, suffering from various nutritional disorders and the majority of cases we have been able to keep under observation for at least a year and have seen the after-effects of our treatment.

At the beginning of our work the two diseases which seemed hardest to combat were marasmus and diarrhœa. It is to the consideration of the latter disease, so called summer diarrhœa, that I wish to call your attention in this paper.

During the first summer of our work we were terrified and overwhelmed by the number of rapidly fatal cases of diarrhœa which came to our attention and one fact was immediately impressed upon us, namely, that there was and still is a large field for prophylactic treatment of summer diarrhœa. This preventive treatment is largely in the hands of the general practitioner and I believe it to be his duty as the hot weather approaches to start in with a systematic campaign of education for the purpose of preventing summer diarrhœa.

We all know that the weakling, the poorly nourished infant, the infant that has been fed on artificial food or on insufficient food is the one that succumbs to diarrhœa. Rarely do we find a fatal result from summer diarrhœa in a breast-fed infant. Mothers then, must be taught that the time to prevent diarrhœa is before the hot weather comes on, the infant must be



examined and its food regulated and every effort made to increase its resistive power. The mother must be taught the importance of early treatment.

In our own work we have constantly instructed mothers to dilute the food which the baby receives on hot days, to resort freely to tepid baths, to be absolutely certain of the freshness of the milk supply and at the slightest signs of vomiting or at the first loose movement to stop all food, giving only water for twelve hours, following that with barley water until the stools are normal in consistency, then returning gradually to milk formulas.

We have not found it advisable to administer castor oil or any other cathartics. Five years ago this was considered malpractice, but now the more advanced among pediatricists are abandoning the use of castor oil in such cases.

Such simple dietetic measures as these, if inaugurated at the very beginning, will stop the average attack before it develops into a true diarrhœa. The digestive organs are calling loudly for rest and the infant will recover if Nature is helped in this way, assuming that the infant has sufficient vitality and sufficient resistive force to overcome the infection.

What are we to do with our bad case, with our neglected cases, with the cases which have been improperly fed and improperly nourished and have only the narrowest margin of vitality to draw upon? In the past we have been content to put our dependence upon cereal gruels, stimulants, and in some cases, intestinal irrigation. But I wish to call your attention especially to a method which bids fair to supersede the methods previously employed. I refer to "Casein Milk."

In 1910 Finkelstein and Meyer, of Berlin, after a long series of experiments, advanced some new theories as to the cause and treatment of diarrhœa in infants which are being generally adopted throughout the world.

In brief, they have concluded that milk sugar is the offending agent in these cases; that by its fermentation the functional weakness of the intestine is increased; that by eliminating the sugar from the food the intestinal epithelia tends to recover its normal strength and that this process of repair is still more increased by the addition of finely divided casein.

As a result of their experiments they have devised a preparation known as "Eiweissmilch" (Casein Milk, Albumin

Milk), which is prepared as follows: Heat one quart of whole milk to 100 F. Add four teaspoonfuls of pepsin and stir. Let the mixture stand at 100 F. until the curd has formed. Put the mass in a linen cloth and strain off the whey from the curd. Remove the curd from the linen cloth and press it through a fine sieve two or three times by means of a wooden spoon or mallet. Add one pint of water to the curd during this process. The mixture should now look like milk and the precipitate must be very finely divided.

In the original experiment this Casein Milk was reinforced with an equal amount of buttermilk, but in my own work I have omitted buttermilk and have used instead, top milk, to increase the caloric value of the food together with malt sugar.

The Casein Milk itself contains about one half of one per cent. of sugar. Some experimenters report difficulty in its use because of the absence of the sweet taste, but in my own work there has been no trouble of this sort. It may be sweetened, if necessary, by adding saccharin.

The casein milk is used plain instead of the usual twenty-four-hour fast or water diet. In from twenty-four to forty-eight hours the stools become yellow and less frequent. Malt sugar may now be added to the mixture. I have found that Dextri-Maltose of Mead, Johnson & Company, to be the most satisfactory. This malt sugar is made by the action of diastase of potato starch, the resulting mixture contains about 55 per cent. of maltose and 35 per cent. dextrin and no free starch. Its caloric value is about 110 per ounce.

It seems to be more digestible than milk sugar and may be used in larger amounts than milk sugar without fermentation. I use this preparation in the majority of cases in the proportion of two ounces to a day's feeding. It raises the food value of the mixture and helps to keep up the weight in the interval between the beginning of normal stools and before a milk mixture can be tolerated. After about five or six days ten ounce top milk may be added to the casein milk, in small amounts, four ounces at first, increasing two ounces every other day until the normal formula is being given.

This method of treating diarrhoea has many advantages. The food is not difficult to prepare, it acts quickly, it keeps well and it is retained well. Unless properly used there is great danger of under-feeding, but with reasonable care the most severe cases come through with only slight loss of weight.

The question of its applicability is still open. The Germans use it in all cases of diarrhœa, but it may be that they are over-enthusiastic. Only time and the observations of many men can give us the information necessary to classify the cases which are most helped by it.

During the past summer I was able to study twenty cases of severe diarrhœa under this method of treatment. Six of these cases ultimately died and fourteen recovered. The deaths, however, were the result of an underlying condition like marasmus or pneumonia, or the babies were in a moribund condition when the treatment was begun. It was noticeable, however, that even in the cases that died, the number of stools were decreased and the intestinal condition benefited by the use of casein milk.

The cases that recovered were fed on pure casein milk until the stools were normal in color and consistency, an average of five days. After this, top milk was gradually added to the casein milk until the infant was receiving its normal formula, when the casein milk was discontinued. The average time required to accomplish this was about five days. During this period one infant gained in weight, the others lost or remained stationary but the loss in weight was not as marked as in the former methods of treatment and with a more liberal use of malt sugar I believe that wasting would be eliminated in the majority of cases. None of these cases received castor oil or other cathartics, no rectal irrigations were given and no medication was given.

In practice I think we shall find that certain cases will be cured by the use of cereal gruels while others will be helped by casein milk. One thing is certain, however, casein milk is a help in the treatment of a troublesome condition.

#### DISCUSSION.

DR. WESTNEY: I think Shakespeare says, "There are more things in Heaven and earth than you ever dreamed of in your philosophy."

Here comes a man who says that the trouble is with the milk sugar. I expect to hear a man say that the trouble is in the salt of the milk. The character of the paper is very fine. It shows that it is written by one whose heart is in his work, and who has told us what he has learned, based upon his experience.



I think a woman with a bottle-fed baby should have an antiseptic conscience. As to castor oil, I am for the old fashioned castor oil.

Personally, I have not had trouble with fat indigestion. I have thrown the curd away, and have always used the whey. I have wanted to get rid of the casein. I have had cases where in the preparation of the whey I did not take off a sufficient percentage of cream from the top of the milk, and the baby could not digest the milk. But I threw the casein away.

But I believe the strength of the baby's digestion is in the proportion of the amount of casein it can digest. I think it is a more practicable method to put our babies back on casein. If my baby has casein indigestion I go right back to my whey. I shall certainly use the doctor's method of subdividing the casein. It makes it more like the mother's milk. I think at times we must remember there is casein indigestion, fat indigestion, and carbo-hydrate indigestion in infants.

DR. KRICHBAUM: I shall not discuss the paper, but the essayist relieved my mind by telling us he had eliminated cow's milk from his diet, but the discussionist said he put it on. I don't know where I am at. I would like to hear from Dr. Simonson on that.

DR. SIMONSON: I think Dr. Benson deserves a great deal of credit for this exposition of the new milk, Eiweissmilch or albumen milk, whatever you call it, made by Dr. Finkelstein in Berlin, has been spoken of. He was the man that started the crusade against milk sugar. It was taken up and followed by Dr. Coite in Newark and Dr. Le Fetra in New York. Dr. Le Fetra has shown that milk sugar can be used not only as a diuretic, but as a laxative, and he uses it in cases of constipation in children, and where there is a tendency to loose bowels. This subject of Eiweissmilch was brought to my attention by Louis Fischer in New York, who took it up rather enthusiastically. I started up with it. I don't know whether German babies take it better than American babies—like buttermilk. I tried fermented milk and buttermilk with American babies, but it was a dead failure. I had to stop it. But my experience with Eiweissmilch—and it has been a fairly large one, although I think not as large as Dr. Benson's—I am afraid of fats, very much afraid of fat; like Dr. Wescott, of Philadelphia, for years I have been so afraid of them, some of my colleagues have said I had fat on the brain. On the question of fats—infant feeding—I think that this trouble except as applied to cow's milk is very largely fallacious. I think you have a tremendous amount of trouble with cow's milk that does not appear in human milk.

Cow's milk and human milk, as far as quantity of fat is concerned, are identical. They each have four per cent. of fat, but the fats are entirely different. That is the reason I have been afraid to, as Dr. Benson talks about, use this top milk, in addition to diluted casein. I have used it, nevertheless, in this way: if I have a gastroid case, a gastro enteric infection or milk infection, with inflammation of the stomach, and of the small intestines, and I get a symptom choleric in character, I do not use top milk. I am afraid to in a case of entero-colitis.

That is the way I separate them. In entero-colitis I use the top skim, and in cases of gastro-enteric infection I am very apt to use skimmed milk or a milk where you are going to have low fats.

I also use Meade's dextro-maltose. I like it better than milk sugar. There is no danger of fermentation and of the bad results of fermentation. But I think the trouble with milk sugar is not in the milk sugar *per se*, but with the character of the milk sugar in America. Most of it is villainous stuff.

DR. FOSTER: I have used dextro-maltose and found it more satisfactory than milk sugar.

DR. RAUE: I have enjoyed Dr. Benson's paper very much. I am glad to see the character of work he is doing. We are doing the same thing in Philadelphia in conjunction with our City Hospital. We are holding mothers' clinics every week, we have the mothers bring their babies to the dispensary and different members of the staff give them little practical talks on the care of the baby, methods of preparing food, symptoms of disease, indications for change of food and so forth, and give them the rudiments of infant feeding, above all, tell them what to do in case of accident and in any acute illness. At this time of the year we are especially busy in warning them in personal cleanliness, as well as cleanliness of feeding utensils—bottles and nipples—and in being careful with the milk; and we have a visiting nurse. If any of these children are sick, to visit them at their homes, and instruct the mother how to prepare the food. The mothers bring the children to the dispensary and we weigh them every week, instruct them how to prepare the food, if the children are sick look at them. In this way we are doing a great deal of work. It is wonderful what can be accomplished.

Eiweissmilch is an excellent food. There is no doubt about it. I was in Dr. Finkelstein's hospital when he was experimenting with it, and I saw the wonderful results he was getting. Under such surroundings the results are ideal, but we cannot get the poor people to work foods as complicated as that unless we supply them with the food, and in private prac-

tice, as a rule, you cannot carry it out unless you have a trained nurse. So I have found in comparing the results with these more complicated methods in the ward work at the Children's Hospital, I get pretty nearly the same results by the use of skimmed milk, and diluting it, above all boil it. We have known the fact that if you mix with the milk the same amount of flour- or barley-water and then boil it, for some reason or other the child is not so likely to vomit or to have bad stools. As a simple method of treating summer diarrhœas, when you have not returned to milk, probably the safest thing to do is to give them skim milk, add to it a flour or starch solution, and boil it. You would probably get as good results as with Eiweissmilch.

DR. YOUNGMAN: I am interested in what the doctor says about skim milk and barley. Skim milk and barley seems to be a good milk to give them. Ronley speaks of this milk. I used it in some cases last summer, but it is extremely difficult to get the average mother, with the average intelligence, to carry it out. In one case I used it in what I am sure was simply an ordinary attack of indigestion from overfeeding. The baby was doing very well when I began to use this, with a trained nurse whom I thought was very reliable—I think we are apt to take that for granted—I think she overfed the child, because I had a serious case of colitis, lasting two weeks, and I had to work hard to save the child.

I am afraid of fats. I am like Dr. Simonson. I am afraid of sugar, too. I think your babies will do better on a formula without the sugar of milk. I think malt sugar is more satisfactory and safer. For a number of years I have not been using the top milk very much. I use either the lower milk or skim milk.

As to castor oil, I am like Dr. Westney. I am a believer in castor oil. I think theoretically, if these mothers would take the precautions that we give them, in their feeding, we would not need castor oil. It is good as a routine treatment, but unfortunately they do not take the precautions, and we are called in, the child is sick; you do not know what the condition of the intestines is, castor oil or sulphate of magnesia is a good way to start your treatment, and have a look at your stools. A little later I have good results with albolene. That is a very good form of Russian mineral oil, which seems to be non-irritating upon the intestinal tract. The children do not object to the Russian oil as they do to castor oil, as it is more palatable, and a drop or two of wintergreen or peppermint will make it more so.

DR. ECKINGS: I think that Dr. Raue's suggestion about



boiling milk is a good one. It is the custom of a number of pedologists to order milk to be boiled, between May 1st and October 1st. That is sometimes the routine custom of pedologists.

I would like to ask Dr. Benson, before he closes the discussion, whether he has figured out the caloric value of Eiweissmilch, whether he depends on caloric feeding in the prescribing of that milk.

DR. BENSON: I am flattered and pleased at the free discussion of my paper. I did not intend to go into the theoretical points in connection with Eiweissmilch. I hope I am not a faddist, and I am not experimenting. In fact, for this two years back this method has been in use, and I used it in the beginning with skepticism, but I think we are going to get the results by the methods that have been mentioned. Our results last summer were so marked and so astonishing, compared with what they had been in previous summers, that in spite of myself I had to use casein milk. It may be due to two reasons. We get in our care only very bad cases. In private practice I have had no difficulty in the preparation of the casein milk, provided I take the pains to instruct the mothers how to prepare it, and what to expect. Only in the majority of cases they threw the bottles away, because they thought the babies were getting sour milk, because there are the fine particles in it.

It may be some consolation to Dr. Westney to know that salts are responsible for most of the convulsions.

I have purposely not gone into the theoretical side of this question. I am not prepared to answer Dr. Eckings' question about caloric values. The values have been figured out. They are, of course, low, but we depend practically upon malt sugar to raise them to a point where they are of practical value.

As a matter of fact, in my own work, I have been afraid of fats and salt and sugars, but I am much more afraid of diarrhœa—the bad cases of diarrhœa we are up against sometimes. If by any method, I don't care what, I can treat my case of bad diarrhœa, that would have died last summer, so that it gets well, I am going to take off my hat to the man who devised the method, and give it a full trial. It is not for the purpose of defending the theory that I have prepared this paper, but I want you to investigate the subject and give it a trial in your hopeless cases.

**CARE OF PREMATURE INFANTS.**

BY

WILLIAM H. COOKE, M. D., EAST ORANGE, N. J.

THE care to be bestowed upon a little puling infant born at the seventh or eighth month of uterine life differs materially from that required by the healthy squalling youngster which comes ruddy and bouncing into life at the normal term of pregnancy. The full-born child requires a moderate toilet and will prosper under many adverse conditions. The premature child causes anxiety from the moment of its advent into the world.

The first care he requires is to make him breathe, for he is usually born pale, cold and still. Violent efforts at resuscitation do not suit this precarious life. The best means is this: A No. 1 catheter pushed through the nostril into the pharynx. Stand over his head facing his feet, place the end of the catheter in your mouth. Dispose your hands on either side of the head so that as you blow through the catheter to inflate, your thumbs and forefingers keep the baby's lips and nostrils tightly closed. After full inflation bring the remaining fingers down against the chest wall to collapse it; employ this inflation and compression rhythmically eighteen times per minute. Meanwhile have the nurse with her hands strongly compress the abdomen upward against the ribs to prevent the air blown in from entering the stomach. In practice we have found this means eminently successful and much in advance of the older methods of swinging and heating.

It should always be remembered that the main thought with a premature infant is low vitality. Therefore think at once of external heat. Keep up the warmth by outside adjuvants. It is well to have it in a very hot atmosphere and a warm bath ( $100^{\circ}$  to  $102^{\circ}$ ) while resuscitating. Immediately when it begins to breathe, prevent radiation of its small store of bodily heat by enveloping thickly in cotton batting—not absorbent cotton. Pay no attention to the skin or the toilet. Get it into a permanent temperature of  $90^{\circ}$  and keep it there. Remember that cool air inhaled carries off more heat than cool air striking the skin. Therefore the only proper means of securing such a permanent temperature is the incubator.

Now a word about incubators. The surgical supply house

incubator is a beautiful and perfect mechanism, but, early in my work with babies I found that it was never on hand at least in the first few hours when its use was most important. It was too costly and fragile an article to stand transportation from house to house in the nearest dray. Then I borrowed an automobile that stood ready to go for it and it took several hours for a moderately experienced nurse to come to run it. The baby perished while we were making all the elaborate preparations to save it. So I had a good cabinetmaker make me one that would go anywhere, could stand anywhere and could be set up and learned in ten minutes by any average woman, and could not be spoiled. This is about the size of a small bureau and has an under compartment, containing a long copper tank, holding  $2\frac{1}{2}$  gallons hot water ending in a draw off faucet outside, and a funnel for filling. This projects outside six inches and under it is placed a Bunsen burner or alcohol flame to keep it hot. Above the trunk is a shelf on which the baby lies on a pillow. The top is a glass window opening like a shutter, through which to observe the infant. A thermometer is hung above the baby on one wall. Ventilating holes in the top and bottom, closed by sliding copper shutters, secure free ingress and egress of fresh air. The whole apparatus can be made for about \$22.00.

The baby is gotten into this at once—dressed thus—a little flannel shirt coming down over the hips, a soft diaper enveloping the whole lower parts from the waist down, not brought between the legs; a pad of soft cotton over the anus, now envelop the whole baby in a light layer of cotton batting. The temperature of the incubator must be kept between  $89^{\circ}$  and  $90^{\circ}$ —night and day. It must not be in a drafty place, but the air entering must be fresh; another point—do not have it in the room with the mother.

Now as to feeding. The premature child must be fed frequently. Every hour and a half is none too often. The amount taken will be small at first—1 to 4 drachms. This is best administered by means of a medicine dropper. At first start with 5 per cent. sugar solution, made by dissolving sugar of milk in boiled water. In a day or so condensed milk in weak solution, and in one week peptonized milk. Meanwhile if the mother's milk comes in this should be drawn with a breast pump and fed to the baby.

The child must not be taken from the incubator for any pur-



pose. When it soils the cotton this is removed through the shutter and a fresh one substituted. The child is not washed but rubbed and cleansed with olive oil—all through the raised shutter. No water need be used for cleaning. Continue frequent feedings. The amount taken will increase to 6 drachms, then 1 oz., then 1½ oz. This incubator life will have to be kept up for at least one month, perhaps two, until in fact the baby is about two weeks older than normal term. Then it can be taken out to nurse naturally and replaced for a week or two more.

I have just had in my incubator a child born at the incredible period of six months, one week of uterine life and it has prospered. It weighed two pounds four ounces at birth. In one case, for the purpose of frequent withdrawal of the mother's milk, the father suggested the plan of using an automobile grease-gun for making suction and this worked admirably. It is astonishing how these pale, meager, almost lifeless little people prosper under this hot-house, forcing method of treatment, and do well even when fate seems to have destined them to early extinction.

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#### A CLINICAL DEMONSTRATION OF SOLIDIFIED CARBON DIOXIDE REFRIGERATION.

BY

FREDERICK DEARBORN, M. D., NEW YORK.

THIS will be a brief clinic and there will not be very much order about it. We have here two cylinders of carbon dioxide. We take some of this snow, which Dr. Withington has just made from the solidified carbon dioxide, and dissolve it in ether and can then put it in practically any shape. If it is in plastic (partial) solution we mold it. We may use it in pencil form, or we may mold it with our fingers to the shape of the scar or mark we intend to treat, or by thinning with more ether, we may paint with it. If we do not wish it to get hard we collect it in a vessel of wood instead of ordinary metal. The work is not new; it is about eight years old; although it has been exact for only about one year. We may lay it on, or press it on with a little pressure or with deep pressure, the length of

time depending upon the nature of the disease. It varies from ten seconds to two minutes. We have to be careful in using it in certain portions, particularly on the mucus membranes. We expect after it a certain amount of congestion and redness. The period of resolution covers from ten days to three weeks. It is impossible to do anything to the lesion again until after that time; for instance, we use it from four to six times in a year, and so get perfect results without scarring. We do not get any necrosis or scarring. If you do get necrosis you have applied it too long. There are a few diseases for which it stands pre-eminent, because they seem to be influenced by this "snow." (The reason we call it "snow" is that it looks like it.) Among them are lupus vulgaris known as the tubercular form of lupus, and other forms; and moles may be treated by this method. By this I do not mean warts. I read a book recently that said that forty-six conditions may be treated by "snow." I venture to say that twenty-eight of them could be better treated in some other way. It is not to be "slapped" on every case. I will admit we have done some slapping in our time. When we started in we put it on a good many things we don't put it on now. We have used it probably five hundred times.

I am going to show you a case of naevus pilosis or hairy naevus. (Anybody that attempts to freeze a hairy surface before the hair is destroyed is wasting time.) There is the growth. We never freeze the vermillion proper of the lips.

Here is another child with a growth probably as large as a fifty-cent piece,—a cavernous angioma. I do not know of any other method of treatment that has ever removed a case of that kind without a scar.

About two years ago this man was cut with a razor. As the hurt was slight and he was in health, the wound evidently healed without suppuration, and has left an imperfect scar. We have applied the treatment about six times during the course of the last fourteen months. The scar is now level with the surface, and the indurations have practically disappeared. There is only one place where the scar is still visible.

Here is a young lady with false keloid. Here is a case of warty naevus. Here is one of luposa erythematosus. The lesion is superficial. We are not going to do anything but paint it,—not put anything solid on it. Here are two patients that have never had anything done with the spots. One is fifty

years old and one twenty-five years old. They are birth marks. The first one is neither superficial nor deep; it calls for intermediate pressure. Some fine day I hope to bring this young man back here and show you that he is well. (While the doctor was speaking these various patients were treated by an assistant, Dr. Withington.)

I have been asked what the after-treatment is. It consists in leaving the area treated alone and protecting it with antiseptic gauze. If there is any oozing or any serum, always warn your patients not to pick it off. It is always true that the more you pick it, the more you run the chance of getting a scar. As to treating them again,—our routine practice is to treat them again after three weeks. If the patient is in no hurry we are perfectly willing he should go longer than three weeks.

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## THE SIXTIETH ANNUAL SESSION OF THE NEW JERSEY STATE HOMŒOPATHIC MEDICAL SOCIETY.

### BUSINESS TRANSACTIONS.

First Session. Wednesday afternoon, May 7, 1913, 2 P. M.  
The meeting was called to order by the President, Dr. Frank P. Ekins.

Invocation was pronounced by Rev. Wilson R. Stearly, Rector of St. Luke's Church, Montclair.

Upon motion it was ordered that the roll call be omitted and that the secretary note the names of those present.

Motion was made, seconded and carried that the Chair appoint a Nominating Committee of three, to report immediately after dinner on the following day, with recommendations for all offices, and that thereafter nominations be received from the floor.

The President appointed Dr. McGeorge, Dr. Cyphers and Dr. Cornwall.

The minutes of the previous annual session of the Society were read by the Secretary and on motion approved.

The president called for the report of the corresponding secretary. Dr. Hadley, corresponding secretary, being absent, a letter from him was read, stating that at this writing it is doubtful whether he can be present at the meeting, and that he had no report to make, as no business has been done through



his office, and suggesting a change in the office of corresponding secretary since he has held that office for the past six years.

Upon motion, the report of Dr. Hadley as corresponding secretary was received.

The treasurer, Dr. L. E. Hetrick, submitted his report, which was received and referred to the Auditing Committee.

The president asked for the

#### REPORT OF THE NECROLOGIST.

DR. WALLACE McGEORGE: I have not been informed by any member, of the death of any member of the Society, directly. Through the magazines and through correspondence I have heard of the death of several members. So far as I know, all the members of the Society that have died this year have been Dr. Joseph Curry, of Beverly; Dr. Woodruff, of Boonton; Dr. Charles D. Holmes, of Rahway, and Dr. Cheeseman, of Swedesboro. I just heard that Dr. Cheeseman was a member of the Society. Are there any other members of the Society that have died within the year?

Having just heard that Dr. Cheeseman was a member of the Society, I have no record or memorial prepared for him. I ask permission of the Society to prepare one and hand it to the secretary.

A motion was made, seconded and carried that the report of the necrologist be received.

DR. KRICHBAUM: I would like to add that Dr. Woodruff was also a member of the International Hahnemannian Association. I mention that because she was active in it up to the time of her death.

DR. McGEORGE: She really died in harness.

The president called for the

#### REPORT OF THE LEGISLATIVE COMMITTEE.

DR. ATKINSON: The year just passed has seen the most important changes made in medical legislation since the establishment of the State Board of Medical Examiners, in 1891.

There have been about thirty-two bills presented to the legislature, which were directly related in some way or other to physicians or to the practice of medicine. The most important of these were Senate 364, which revised the definition of the phrase "practice of medicine;" making the latter include *anything* which was done for the relief or cure of the sick. This bill (the text of which I have here, and which may be seen by those who desire to see it) is a step in the right direc-

tion, but needs revision in its phraseology. The bill did not pass, however. Another, and perhaps the most important of all those introduced, was Senate 49, which did pass. This bill, with its "sister bill" Senate 253, adds one member to the State Board of Medical Examiners, making that body now consist of ten members instead of nine, and designating that this new tenth member shall be an osteopath; and requiring that all persons desiring to begin the practice of osteopathy shall first pass an examination before the board on all the subjects required of candidates of other schools, except materia medica and therapeutics, in lieu of which the osteopathic candidate is examined in the theory and practice of osteopathy; requiring that all those who are now practicing osteopathy, and have done so for a year, shall within three months register themselves with the examining board and with the county clerk; granting licenses to licentiates of other States reciprocating with New Jersey; licensing the holder of a license under this act to practice osteopathy and nothing else; defining osteopathy; and granting to the osteopathic member of the board the right of sole judge of the qualifications of the schools of osteopathy from which the candidates come.

This is the most sweeping legislation we have had for a good while. The old school society never intended to give in and recognize osteopathy, but the pressure became too great and they did so, but they relieved the pressure in this way: they were first assured that the osteopathic member of the board was to be an old school man who had studied osteopathy, and they accepted this year as the most propitious time to allow osteopathy to come in. Dr. Granbury, of Orange, is the osteopathic member.

We have had another curious thing happen. Governor Wilson appointed an old school man to take the place of Dr. Ubelacher, whose term expires in July. Owing to some possibility of question of illegality in the matter of appointments by Governor Wilson, all his appointments were confirmed, or rather re-made, by Governor Fielder; among them this one, of Dr. McDonald. His name came before the Senate six times before it was finally confirmed. Before the final confirmation Dr. Cornell and myself, the Trenton members of the Legislative Committee, and also by letter, a number of the members of the society, communicated with Governor Fielder and with various members of the Senate and Assembly, to have them turn down this nomination, if possible, but we got nothing but the cold shoulder. Governor Fielder said that the nominations had been made and confirmed, and he didn't propose to unmake them. After consulting with the Attorney General,

and on the advice of the various members of the Executive Committee with whom we were able to communicate, Dr. Cornell and myself employed counsel, with instructions to oust this Dr. McDonald as being illegally appointed and holding office illegally. We find that the procedure will be simple. We have to get the Attorney General's name, I believe, as prosecutor, and under his name we prosecute Dr. McDonald under what is called a quo warranto proceeding in the Supreme Court, as to why he should occupy the position he does, and unless he is able to show he is a homœopath, the Supreme Court will issue a writ of ouster and tell him to get off the board. In my letters to some of the members of the Executive Committee I suggested that possibly Dr. McDonald will be able to show that he is perhaps as much a homœopath as some of the rest of us, but in talking that over with the Attorney General the question was simply asked—"does he hold himself out to be a homœopath?" "no;" "then he has no right on the board." It will be interesting to watch the outcome of it, and before we are through with it, it is possible that homœopathy will get such an advertisement throughout the State as she has never had the opportunity to get before. A great many people believe there is no difference between the two schools except in the size of the dose. If this comes before the court we will have the opportunity to show them that this is not the only difference.

In connection with this appointment, and in connection with other legislative matters, I would certainly like to urge upon all of you who know anything about politics and legislation in general, to assist those of us who are in Trenton, in finding out who our friends are in the Senate and House of Assembly. The old school have a Senator, a doctor, Dr. Ramsey, who looks after their interests. He is there for that purpose. Dr. Carhart is in the House of Assembly for the same purpose. Those men do not tell the old school society what has happened. They keep the society informed of what is likely to happen, and keep them well informed, too. I know that some of the old school men in Trenton told me that they knew a good while before this Dr. McDonald was appointed, that he was going to be appointed; admitted that they knew of matters of legislation which were going to come up long before any bill was presented. We of the Legislative Committee in Trenton have been in a measure helpless in the matter. All we could do was to get the bills as fast as they came from the printer, and go over them. We want the assistance of every member of the Society in our legislative work. If we are to continue we must have it, if we are to have any hope of success.



The one thing I do urge on the Society is that you seek out our friends who are in the legislature, and keep the members of the Legislative Committee in continuous personal contact with them, so that we may know what is going to be done, and not have to fight it after it is done, as in the matter of this appointment. As to other matters of legislation, I have none of the bills here, but they were mostly in regard to the establishment of hospitals and to the new duties on the part of the Boards of health, and do not directly concern us as a school.

The old question of the establishment of a State Hospital for the Insane comes up continually, but I doubt very much whether we are able politically or financially to push such a thing through. No homœopath is allowed to attend any inmate of any of the insane hospitals in the State, so far as I know. We are permitted to attend the attendants and officers of the State hospitals for the insane, but that is pretty well frowned upon too. So far as I am aware, we have no place whatever where we may attend upon the insane of the State. Pennsylvania has a magnificent hospital up near Easton. New York has a grand hospital at Rochester, and another at Middletown, and the people of our State should somehow have the benefit of homœopathic treatment. Homœopathic treatment of the insane certainly bears comparison favorably, to the old school, perhaps more than in any other branch of medicine.

THE PRESIDENT: I think the report of Dr. Atkinson, of the Legislative Committee, has been very instructive. I hope it will bear fruit, and that everyone will interest himself in the matter of legislation.

Upon motion the report was accepted and ordered spread in full on the minutes.

DR. CORNWELL: I don't know the attitude of the old school in the State, but the old school in the board were opposed to this appointment of Dr. McDonald, because it is illegal and it renders the board illegal. If this does not come up before the court and the position is not declared vacant before the June examinations, the board is illegally constituted, isn't it?

DR. ATKINSON: No. That is what the different members of the board have thought. Now, I understand that that is not so. So far as the attitude of the whole board is concerned, it is opposed to this man being seated, but they as a board can not do anything. They have tried to persuade Dr. McDonald that he ought to withdraw, but he would not do so. He "must have it;" he thinks it is about twelve hundred dollars a year in it. Of course he is mistaken. I would like to hear about the legality of the board. It seems to me it would be illegal as

long as the statute says there must be three members of the board, homœopaths.

DR. CHURCH: I think this is a very important matter. I have good friends among the allopaths, who will do anything for me,—as much as any homœopath will, and as good friends of mine; but that is not the question. It is a question of what our legal plan is. If it is proper I would like to make a motion that the Legislative Committee be instructed to push this thing to the limit to get our rights, and that we now endorse the work of that committee in this direction. They have been going ahead, as I understand it, without absolute authority of the Society.

DR. KRICHBAUM: I do not think that the motion is necessary for the simple reason that the members of the committee are earnest men; they will do it anyway. But I do think we should endorse what they have done.

DR. CHURCH: I did not mean to imply that they needed to be instructed to go on, but to endorse what they have done, and to tell them to go ahead.

DR. WESTNEY: Can the chairman of the committee give us any idea of the possible expense of this thing?

DR. ATKINSON: We have employed counsel at the suggestion of the balance of the members of the Legislative Committee with whom we could get in contact, and some of the members of the Executive Committee.

I am very much pleased with the way in which you have taken this matter up, and that we be empowered to go ahead with this business. I think there is no doubt that this matter should be pushed to a conclusion, and Dr. McDonald ousted from the board. Otherwise we will have this thing shouldered upon us year after year. I know that some of the old school men have told me that they have gone to Dr. McDonald and asked him to resign, but he said he would not, and that it would take more than two years to get him out. As to the expense, the lawyer whom we have employed is not a man of very wide reputation and therefore should not be very expensive, and the procedure which he must necessarily follow is a comparatively simple one, as we are assured. I can assure the Society that if we are granted *carte blanche*, as some one suggested, the expense will be kept down to the very lowest possible penny. If that does not satisfy you I would be pleased to have somebody here say how much we will be expected to spend. We would like to know, too.

DR. STRAUGHN: I think it would be a good plan if the Legislative Committee had a representation in each county;

that in that way we might keep in closer touch with the political situation.

DR. C. H. CHURCH: It seems to me that we have before us in the methods of the osteopaths, an example of just what is necessary for us to do if we are to succeed. It is a little embarrassing to have to own that the osteopaths have shown us how to do some things we did not know how to do before. They have shown us how we will have to work. They work through every string they can possibly pull.

DR. ATKINSON: I would like to add to what Dr. Church has said. There were two factions of the osteopaths, both fighting each other hard; but both clamoring for recognition. As showing what can be accomplished, I would like to read assembly committee majority substitute for Assembly Bill 49. It leaves the homœopaths in the shade completely. It gives to osteopathy something which we have not, and which we ought to have; it provides that the osteopathic member shall conduct the examination in the principles and practice of osteopathy, and shall alone determine and decide for the board, the standing of osteopathic schools and colleges. That is something the homœopaths are not allowed to have. It is something we will have to fight hard to get, but it is something which belongs to us.

#### AMENDMENTS.

The president announced that the matter of the proposed amendments to the Constitution and By-Laws would now be taken up. The various amendments were read by the secretary and acted upon as follows:

First Amendment. Insert the words "five trustees" after the word "censors."

Dr. Wintsch spoke in favor of the motion. The president announced that a two-thirds vote would be necessary to carry the amendment, and the question was put, and the amendment declared carried.

Second Amendment. Insert in section 6: "The censors shall receive and examine the credentials of candidates for membership, and report to the Society for election such members as may be found properly qualified. One member of said board shall be elected at each annual session, to serve for a term of five years. At the first election, however, the censors shall be classified as to their terms of service, by lot, one member to serve for five years, one for four, one for three, one for two and one for one year."

Dr. McGeorge, Dr. Charles H. Church, Dr. Wintsch, Dr. Cyphers, Dr. Hetrick, and others, spoke upon the amendment.



As first reported by the committee, it was amended to read as above, and then put and carried.

Third Amendment. "Trustees. One member of said board shall be elected at each annual session, to serve for a term of five years. The trustees shall have general control of the affairs of the Society, and shall make, adopt and amend such rules and regulations as shall be deemed expedient for the conduct of the Society."

Dr. McGeorge moved that the amendment be amended to include choice by lot, as in the case of the censors. The motion was seconded and carried.

On the request of Dr. C. H. Church, the secretary read the powers given to the trustees. Dr. McGeorge suggested that "there be delegated to the trustees such matters as properly pertain to their office," and that the word "legal" be inserted before the word "affairs." His suggestion was put in the form of a motion and was seconded and carried.

The amendment was then put in the following form and carried:

Trustees. One member of said board shall be elected at each annual session, to serve for a term of five years. The trustees shall have general control of the legal affairs of the Society, and of such matters as properly pertain to their office. At the first election, however, the trustees shall be classified as to their terms of service, by lot, one member to serve for five years; one for four, one for three, one for two, and one for one year."

Fourth Amendment. (The fourth amendment referred to the naming of a committee on resolutions, and a committee on nominations. After discussion, the question was put upon the amendment and declared lost. Upon a question being raised of the vote, it was again put, and again declared lost.)

Dr. Foster reported for the Local Committee, saying that the committee had tried to make everything ready, that they had procured a moving picture machine which would be used in the evening, and that arrangements had been completed for the banquet, and that other arrangements had been made for the entertainment of the ladies present.

#### NEW BUSINESS.

Dr. C. H. Church moved that the expenses of the members of the Executive Committee in attending meetings of that committee be paid by the Society upon presentation of their bills, such bills having taken the usual course of bills against the Society. The motion was seconded and carried.

A motion was made, seconded and carried that the matter of the publication of the transactions be left with power to the Executive Committee.

Dr. Griscom extended an invitation to the Society to meet for its next session at Ocean City, N. J., on behalf of the city, on behalf of the Board of Trade, and on behalf of the members of the profession, promising to the members the same kind of a good time they had had at the last session held at that city.

DR. ATKINSON: If Dr. Griscom can promise us as good a time as we had the last time, I move we go there.

The motion was seconded and carried.

#### PRESIDENT'S ADDRESS.

Dr. Westney took the Chair while the president, Dr. Ekings, delivered his address.

Mr. Chairman, Fellow Guests and Members of the New Jersey State Homœopathic Medical Society.

With the appreciation of the honor and responsibility, which you have given me there comes the realization that, according to the by-laws, it is my privilege and duty to address this Society at the opening of its session. On careful thought I could settle upon no title for this address, therefore ladies and gentlemen, coming before you without introductory title, I shall ask your consideration for a few minutes of some matters of interest to us all.

During some few years of practice the writer has frequently been confronted with several questions, which he is sure we all as homœopathic physicians, individually and collectively, have frequently been called upon to consider.

First, if homœopathy is all that we think it to be, why has it not come to its own e'er this? Why has not the dominant school of medicine, as a body and individually, accepted its principles after 120 years proof of its efficiency in curing disease, or at least why does it not accept it as a side branch or specialty to general medicine, even though under a different name than homœopathy?

Why have not the laity received with open arms the treatment which has shown itself to be so much easier, so much surer and of so much more permanent benefit to their ailments?

Why so common for homœopathic physicians to use combination tablets, empirical prescriptions, local treatments and so forth in their daily work together with or in place of the

homœopathic remedy? And often with a jest at the homœopathy to which they should owe so much?

Why is it so easy for us to prescribe empirically or the homœopathic remedy in combination against the difficulty of using the single remedy, prescribed for the patient or the disease?

Why do not homœopathic physicians as a body have more pride in the system of medicine, which they advocate and which they have proven thousands of times is based upon a law of which they need not be ashamed?

These are a few of the questions, which have many times confronted each one of us. With these in mind, I planned a series of questions, a copy of which was sent to several members of this Society; members chosen so as to include all those of our State, whom I know to be following special lines of work. This plan in order that this report might include a broader and more varied experience than that of a single man. 75 sets of questions were mailed, which brought 33 replies. This report, then, is taken from the experience of those 33 physicians, all members of our society, who were kind enough to answer 13 questions according as their experiences and consciences dictated. To them I wish to express my acknowledgment and gratitude for a material assistance in preparing this address.

The questions were worded as follows:

1. How long have you been practicing medicine?
2. What is your specialty, if any?
3. As a rule, do you rely upon the homœopathically chosen remedy in your daily practice, or do you give first place to local treatments, empirical prescriptions or combination tablets? Give reasons for so doing.
4. Is it your opinion that homœopathy, to-day, is influencing, as it should, the progress of internal medicine? What are your reasons for so thinking?
5. In your judgment, how can we increase this influence?
6. Considering the length of time that homœopathy has been in use, do you think that it is as popular with the laity as it should be? What are your reasons for so thinking?
7. In your judgment how can we increase its popularity?
8. Is it your custom to attend the meetings of the A. I. H. of the N. J. State Society; of your local homœopathic medical Society? Give your reasons.
9. How can we make the meetings of the N. J. State Society more attractive to the homœopathic physicians?
10. How can we, as a society, improve the status of homœopathy among the medical profession?



11. How can we, as a society, improve the status of homœopathy among the laity?

12. How can we, as individuals, improve the status of homœopathy among the medical profession?

13. How can we, as individuals, improve the status of homœopathy among the laity?

The replies to these questions were interesting in their variety, but were generally along a very few lines of thought and from the homœopathic standpoint were very satisfactory. The result of this canvass was an education in the present status and needs of homœopathy.

The answers came from men whose years of practice ranged between 8 and 45. Of the 33 replies, 15 came from specialists, 4 from exclusive specialists.

The answers to question 3 show that all, with three exceptions, rely as a rule upon the homœopathically chosen remedy. The three exceptions happen to be registered general homœopathic physicians.

Ninety-one per cent. feel sufficiently confident of homœopathic remedies to give them first place in choice of treatment. Three use homœopathic remedies exclusively. Thus we have 82 per cent. who use the homœopathic remedy first, but use other means of cure as they think necessary, alone or in conjunction with the homœopathic remedy, and this as a general rule because they do not feel sufficiently proficient in the choice of the indicated remedy.

From this we conclude that 8 homœopathic physicians out of every 10 try the homœopathic remedy and place first reliance in it, but do not hesitate to use other means of treatment if they think themselves, the patient or the homœopathic remedy insufficient to the demands.

Some pertinent reasons given for not relying entirely upon the homœopathic remedy are:

1. "Lack of ability to prescribe accurately.
2. "When I do not think the homœopathic remedy indicated.
3. "Use palliative treatment in order to secure time for selection of the indicated remedy.
4. "Use drugs and local measures to produce mechanical effects or remove the cause of disease: distinct from curative effect."

In regard to the attendance of these doctors at the national, State and local societies, we find that it is the custom of 39 per cent. to attend the American Institute meetings; 76 per cent. to attend the State Society meetings, and 91 per cent. to

attend the monthly or bi-monthly meetings of their local medical societies.

What we can gather from these items is not conclusive, except as they include the general reasons for meeting at all. These reasons are fellowship, instruction and loyalty to the cause of homœopathy. No mention is made of expense, loss of time or distance. Why, then, is it that the American Institute meetings fall so far in the rear in representation from the New Jersey State Society? It has been said (I do not know how truly) that there are more homœopaths in A. M. A. than in A. I. H. It behooves us, friends, to join the American Institute, attend her meetings and support her loyally by every means available to us as individuals and as a society. By so doing we can enjoy the greatest fellowship, receive the highest instruction and give the greatest loyalty to a principle, which has given us a high position in the financial, social and medical worlds.

Question 4 reads, Is it your opinion that homœopathy to-day is influencing, as it should, the progress of internal medicine? What are your reasons for so thinking? Six affirmative and 27 negative answers.

The consensus of opinion is in the negative so far as the present influence is concerned, but on the other hand unanimously affirmative regarding the strong influence of homœopathy upon the progress of medicine in former years, i. e., before the day of most of us here. What an admission that we, many of whom have been born and bred in homœopathic thought and practice, should rest our brains and strength after the magnificent work done by the fathers of homœopathy to advance the cause of medical science. Those early fathers were convinced by trial that homœopathy was the best; we are only partially persuaded by our environment and education. But perhaps that is reason enough, let us see.

Without using names, let us quote freely from the replies of our collaborators. Homœopathy is not influencing the progress of internal medicine:

1. "Because of general lack of skill in prescribing.
2. "Because many graduates from homœopathic colleges practice very little that can be called homœopathy. They seem to have very little faith in it.
3. "Because there are too few good homœopaths and too few who know its limitations and by attempting too much make fools of themselves and homœopathy.
4. "Because the narrow mindedness of the average real homœopath acts as a barrier to the selection of the good things in medicine which are being discovered from day to day.

5. "Because the homœopath does not adhere to his creed. He brags of being 'liberal' without studying old school materia medica and other systems at all.

6. "From lack of fearless advocates and teachers, who progress in knowledge of the materia medica and apply it.

7. "Because the old school are coming our way, but we are too lazy to do the needed studying to get the results we could and should.

8. "Because the poor homœopathic prescribing of the average homœopathic physician and the lack of common sense of the Hahnemannians in the use of adjuvants are the worst things sane homœopathy has to fight.

9. "Because we do not have the needed men to take up the scientific study of our homœopathic system; we are all either too busy or too poor.

10. "Due to the improvement in the old school methods of treatment and the remarkable advance in serum therapy.

11. "Because the old school knows no more of homœopathy to-day than they did 50 years ago.

12. "Because many professed homœopaths do not believe in it and take more pains to secure the dollars than to advance medical science.

13. "Because of a lack of knowledge relative to its application and a skepticism as to its real merits."

I was interested in the answer which read: "Because the principle of serum therapy has some relation to the law of similars." That a principle (serum therapy), in which we wish to have faith and which we are all eagerness to investigate should have "a relation" to a law, which we could swear by and which has been proven to be infallible when the conditions of its action are fulfilled and which for lack of complete understanding of its action we "hide under a bushel."

Most of us agree that homœopathy has undoubtedly influenced medical progress to a marked degree, but the present difficulty is that as general medicine approaches our methods many of us are exemplifying the fable of the dog with a bone, who upon seeing his reflection in the stream, dropped his bone to get what he thought to be a larger one, only to find that he gained nothing and lost what he had had.

Summarizing the replies we find four main reasons for the present lack of homœopathic influence in the field of internal medicine.

1. Lack of scientific homœopathic education, before and after graduation.

2. Lack of loyalty and sincerity to our principles.



3. Lack of broadminded charity towards physicians inside and outside of our ranks.

4. Lack of unity within our ranks.

All negative reasons. If virtues be lacking the condition is indeed sad. Let us acquire these virtues. (We shall decide how, a little later.)

Question 6, considering the length of time that homœopathy has been in use do you think it is as popular with the laity as it should be? What are your reasons for so thinking?

Thirty per cent. affirmative and 70 per cent. negative answers.

The negative reasons include the following:

1. We do not bring ourselves before the laity in the same advanced and up-to-date manner as the old school.

2. We call ourselves homœopaths and use everything foreign to the teachings of homœopathy in our practical work.

3. Because many of the laity in earlier years have had the privilege of engaging the teachers of homœopathy, Hering, Guernsey, Lippe, Raue, Helmuth, Allen and Dunham, and in later times the homœopath of to-day, and they cannot help but see that many homœopathic physicians of to-day practice homœopathy in a half-hearted way.

4. Because there is very little difference to-day between the methods of the average so-called homœopath and those of the average practitioner of the old school.

5. Not as popular with laity as it should be, but as popular as it can be considering the general low standard of homœopathic practice that prevails to-day.

6. Because we do not stick to homœopathic prescribing and often it is difficult for the laity to see any difference between the practicing of the homœopath and the regular.

7. Homœopathy is growing unpopular as such because so many of our most enthusiastic homœopaths shut their eyes and ears to the progress made by other men and won't go at things with an open mind. They base their ideas upon tradition and prejudice, i. e., live strictly according to creed.

8. Because homœopathic physicians are not posing as a peculiar sect; the word homœopathic is being intentionally relegated to obsolescence.

9. Homœopathy is more popular in some localities, depending upon the intelligence and education of the community and number of physicians.

10. Popular only in certain localities where the people have been educated to it.

11. Few of the laity know or care what homœopathy is. This is mostly due to ignorance on their part, adverse criticism

from the old school and lack of advertising and instruction on the part of the homœopaths.

12. People are less inclined to choose their physician by his school of medicine than by his reputed ability to cure the sick.

13. Laity are chiefly interested in the prompt, effectual and safe cure of their bodily ills. When true homœopathy is practiced, cures inevitably ensue if the case is curable to medicine.

14. Mongrellism or worse, the potency question and the fact that some homœopathic physicians send their sons to old school colleges hurt the popularity of homœopathy.

We can gather from these answers that the reasons why homœopathy is not more popular with the laity are comprised under five general headings, namely:

1. Lack of instruction and education of the public.
2. Our lack of loyalty and sincerity to our principles.
3. Lack of sufficient homœopathic cures.
4. Lack of legitimate advertising.
5. Lack of unity within our own ranks.

All these negative reasons given by our own members show where we are at fault in stimulating progress in the field of medicine, through the two economical factors, supply (the medical world) and demand (the laity).

We now come to the vital questions: How are we individually and as a society to stimulate the progress of internal medicine through the general medical profession? and how to increase the popularity of homœopathy with the laity? In other words, *How can we give to the world the best that homœopathy can supply?*

The answers to questions, V, VII, X, XI, XII and XIII: more than two hundred answers from 33 different sources will aid us in solving this problem. We shall condense for ease of comprehension.

1. In regard to the influence of homœopathy in the field of medicine, we must attend first to education; the scientific education of our young men before and after graduation.

The young man goes to the homœopathic college for some good reason, perhaps because his preceptor or family have decided it for him. Or perhaps he wants to study homœopathy at the fountain. As a rule upon matriculating he has formed no opinion of the homœopathy which he expects to practice.

From his first day he is gradually and deeply influenced by the homœopathy as taught there; about as many varieties as there are chairs to teach it. From one chair he learns to ridicule the high dilutionist as a dreamer; from another he is

taught to depend exclusively upon the single dose of the indicated remedy, given high. From a third he is told that only four remedies are of use in pneumonia, and from a fourth he is assured from the experience of the lecturer, that he must not prescribe for the pneumonia at all, that the correct method is to prescribe for the patient and forget the disease. Then again from a fifth chair, this same young man receives the cardinal symptoms of the many drugs much in the form of a story, for ease in remembering.

All of this is interesting, to be true, but rather confusing and so misleading that it will take our student several years of practical experience with these remedies to unlearn much and relearn the meat and practical application of the homœopathy he spent his time and money to learn correctly at first. That is, provided in the meantime he does not adopt mongrellism as the easiest way out of a puzzling situation.

After our student has been sufficiently bewildered in the use of homœopathic remedies, he is next ushered to the bedside, trained in diagnosis and told the routine treatment of these cases in such and such a remedy. Now, what kind of a homœopathic judgment will our young man use when he captains his own ship? Far better for the sake of homœopathy that he be graduated from old school medicine and later taught homœopathic medicine by his preceptor, or by a special post-graduate course, than that he should be graduated from a homœopathic institution with the homœopathy so ridiculously and scientifically inaccurate that he will be ashamed of it or through lack of interest will fail to continue his study of it.

Just before leaving for this session a belated reply came in. We shall quote verbatim from this one of our collaborators: "I believe the homœopathic school is suffering from a lack of homœopathic teaching. I have examined in our State Board in homœopathic materia medica and therapeutics and have discovered an ignorance of the fundamental A, B, C of the matter. When a student, just out of college cannot define a homœopathic prescription and cannot define the term 'Similimum,' and cannot give the remotest reason that homœopathic prescribing has any advantages, they are not going to represent homœopathy very long. I think that the uncertain ideas concerning homœopathic principles is the great cause that retards homœopathy.

Thus we must first secure students with particular stress laid upon the young man of good character and good education; quality more than quantity counts in this 20th century. We must give them the education, which the 20th century demands; not solely the homœopathic education, but a complete



all-around medical education, which will give our graduate the courage derived from confidence. We must remember that his education will be long and his battles many ere he wins success for himself and his profession.

As we are planning to educate him in accord with the present day standard, we must take care that his homœopathic education be just as accurate and scientific. The scientific application of physical and laboratory methods of diagnosis is vital; the scientific application of homœopathic methods to the diagnosis as well as to the patient is just as vital.

Teach our students the science of the homœopathic prescription, its uses and its limitations. Teach him the science of homœopathic philosophy and the science of disease. Teach him the scientific application of homœopathic principles at the bedside, in the hospital wards. Teach him homœopathy as prescribed in the definition given by the American Institute of Homœopathy.

By "scientific" we mean the thorough, complete consistent and harmonious application of his education to the most recent and most advanced state of general medicine. Leave out the "scientific" instruction and we might almost as well leave out his education. A paid corps of instructors in our colleges and especially covering the homœopathic subjects will do much towards this end. It is our duty and privilege as homœopathic graduates and physicians to support morally and financially any such plan in our colleges to-day.

Education after graduation is not to be overlooked, although it vitally depends upon the stimulus received during college years. This stimulus, although received from sincere, educated, scientific instructors will soon wear out unless our graduate physician is imbued with an ever-present ambition to find the TRUTH.

The education of a man is not confined to his school days; the education of a physician is not confined to his college course. We homœopathic physicians must remember that our education is ripened by experience at the bedside; also by meeting and debating with our opponents as well as with our friends; that education breeds open-mindedness towards the unexplainable and charity towards the faults of others.

If each member of this society will register a silent vow to do his part in combating prejudice and thus clear the field for educational discussion, much will be accomplished for the advancement of scientific medicine.

Second. Just as important as the scientific education of our students we as homœopathic physicians will find it imperative to found our principles upon a scientific basis.

The goal of homœopathy is not perfection, but progress.

The law of gravitation is not a matter of opinion; it is capable of absolute proof; it has always operated and always will. So with the law of similars. But we as finite interpreters of that law must study it in its applications and limitations. We must study that law in our daily bedside work; we must study it in the laboratory with our instruments of precision; in the hospital and clinic with their clinical resources. Let us check our results with the approval and accurate methods which modern science has placed at our disposal. Then let us teach our students to do likewise. The result will then not be in doubt and the law of similars will again become a guiding light to medical progress. This might seem improbable to some, but it is simply an appeal for the truth, which invariably implies self-sacrifice.

The laboratory is our greatest aid and we must use it; first to demonstrate the scientific standing of homœopathic principles; second, to reprove our drugs with scientific precision and thereby give us a more practical materia medica; and, third, we must use the laboratory to quiet the dissension arising from the question of dosage; an accurate dosage is as important as an accurate prescription.

#### HOMOEOPATHY AND THE LAITY.

From the canvass taken we find that the layman is not attracted by homœopathy as we feel he should be. How can we account for this? How rectify it?

To influence the layman is simply a matter of results. We must show him that the homœopathic method of cure is based upon a principle, which if properly applied will remove his ailment. The homœopathic family case will do wonders in this direction. We must then deliver the goods in what we know to be the easiest and quickest manner and with a result most sure of permanency. But unless we are sure of our ground and know our homœopathic and individual limitations we must have care not to promise too much, nor to attempt too much and thus by failure make fools of ourselves and homœopathy.

In our successes let us praise homœopathy; in our failures let us blame ourselves.

Results count for both the profession and the laity, for that which does not yield results is worse than dead, it is useless and only consumes space. Therefore, gentlemen, let us preach only what we know; and not more; then let us practice accordingly and get the results. "Faith without works is dead."

If we would appeal stronger to the laity we must get re-

sults. We all want results both for the satisfaction to ourselves and our principles at attaining the goal as well as for the remuneration attending our success. But to attain results we must know how. The greater our knowledge the better our results. We should not need to spend several years after graduation in acquiring the art of applying our knowledge to the cure of the sick. The college education should give us the means whereby we can, after graduation, apply our training in case-taking, physical and laboratory diagnosis and application of homœopathic principles to effect the desired cure; that is if a homœopathic cure is possible; if a homœopathic cure is impossible we should know it and know the curative treatment.

Our students should be well educated in all lines of treatment: therapeutics, mechano-therapy, hydro-therapy, electro-therapy, osteopathy (so-called), and so forth. They will be better armed with a knowledge of their competitors than when too homœopathically self-centered.

Let us have scientific homœopathy, scientifically taught in our colleges. Let us teach our students to prescribe symptomatologically, as well as pathologically, according to key note and according to the totality of the symptoms; teach them the practice as well as the theory of homœopathy. "By their works and not by their mouth they shall be judged," and their methods with them.

Let us turn out graduates, proficient in pathology; expert in diagnosis and specially trained in the scientific use of homœopathic therapeutics. We shall thus and only thus have a graduated medical product well able to treat disease with credit to himself, his principles and his profession.

The attainment of this result demands loyal support of our colleges morally and financially and in the supplying of students for them. We must support our colleges for thence comes our strength.

This reading is the voice of the members of this society in answer to questions put to them. The deductions which I have endeavored to sift out and set down, I trust will prove of help in guiding our energies into the channel of progressive homœopathy.

In closing, ladies and gentlemen, let me recommend that our society appoint or elect a permanent committee of three on propaganda, whose duty shall be to assist in carrying out the plans of the A. I. H. propaganda committee in our State and under the authority of the New Jersey State Homœopathic Medical Society.



A motion was made, seconded and carried that the address of the President be received, and be referred to a committee to consider and report upon it.

The Chair appointed Dr. C. H. Church and Dr. Perkins.

The Chair appointed Dr. Cornell and Dr. Straughn and Dr. Cyphers members of the Auditing Committee. Dr. Cyphers chairman.

# SECOND DAY—MORNING SESSION, THURSDAY, MAY 8, 1913.

The meeting was called to order by the President, Dr. F. P. Eckings. The President called for the report of the Nominating Committee.

Dr. McGeorge reported on behalf of the committee the following nominations:

President, Dr. Alfred W. Westney.

First Vice-President, Dr. C. H. Church.

Second Vice-President, Dr. W. C. Perkins.

Third Vice-President, Dr. F. P. McKinstry.

Recording Secretary, Dr. A. W. Atkinson.

Corresponding Secretary, Dr. Rudolph F. Rabe.

Treasurer, Dr. L. E. Hetrick.

Censors: Dr. B. H. Garrison, Dr. A. W. Bailey, Dr. Howard Ivins, Dr. Charles Hadley, Dr. Adams.

For Trustees: Dr. C. H. Church, for one year; Dr. C. W. Perkins, for two years; Dr. Frank McKinstry, for three years; Dr. A. W. Atkinson, for four years; Dr. F. P. Eckings, for five years.

On motion the Association adjourned.

# SECOND DAY—AFTERNOON SESSION.

DR. CYPHERS: I move that the Secretary cast a ballot for the gentlemen mentioned in view of the fact that no other nominations have been made.

The motion is seconded and carried.

The Secretary reported the ballot cast for the gentlemen named, and the President thereupon announced that they had been elected to the office set opposite their names, respectively, as follows:

President, Dr. Alfred W. Westney.

First Vice-President, Dr. C. H. Church.

Second Vice-President, Dr. W. C. Perkins.

Third Vice-President, Dr. F. P. McKinstry.

Recording Secretary, Dr. A. W. Atkinson.

Corresponding Secretary, Dr. Rudolph F. Rabe.  
Treasurer, Dr. L. E. Hetrick.

Censors: Dr. B. H. Garrison, Dr. A. W. Bailey, Dr. Howard Ivins, Dr. Charles Hadley, Dr. Adams.

Trustees: Dr. C. H. Church, one year; Dr. C. W. Perkins, two years; Dr. F. P. McKinstry, three years; Dr. A. W. Atkinson, four years; Dr. F. P. Eckings, five years.

The report of the Censors was called for by the President, and given by Dr. B. H. Garrison. The report recommended the election of Dr. J. W. Hassler and Dr. Henry B. Orr as members of the Society.

A motion was made, seconded and carried that the report be accepted and that the two gentlemen named should be elected members of the Society.

The meeting then proceeded to the election of officers. The President called for nominations for officers. There being no other nominations than those submitted by the Committee, a motion was made, seconded and carried that the nominations be closed.

#### THIRD DAY—MORNING SESSION, FRIDAY, MAY 9.

The Censors presented the names of four persons for membership in the Society, viz.: Dr. G. Herbert Allen, of Jersey City; Dr. F. H. Long, of Newark; Dr. G. H. Taylor, of Montclair; Dr. M. Lillian Marten, of East Orange.

A motion was made, seconded and carried that the secretary be instructed to cast a ballot for the election of the above named persons. The Secretary cast such ballot, and so reported, and the President declared them duly elected members of the Society.

Dr. Straughn then reported for the Auditing Committee that the committee had examined the Treasurer's books and found them correct. Upon motion his report was ordered received.

The scientific work of the Society was then taken up and continued until Friday afternoon.

Dr. Taylor then moved that their thanks should be extended to the officers of the Society for a very enjoyable session, also to the management of the Montclair Hotel, then to the local committee. This motion was seconded and carried. Upon motion the meeting adjourned that day.

President-elect Alfred W. Westney, of Atlantic City, announces the following list of officers, committees and bureau appointments and delegations for the ensuing year:

President, Alfred W. Westney, Atlantic City.

First Vice-President, Chas. H. Church, Newark.

Second Vice-President, C. W. Perkins, Princeton.

Third Vice-President, Frank P. McKinstry, Washington.

Recording Secretary, A. W. Atkinson, Trenton.

Corresponding Secretary, Rudolph F. Rabe, 616 Madison Ave., New York.

Treasurer, Llewellyn E. Hetrick, 901 Wiss Building, Newark.

Censors: B. H. Garrison, Red Bank; C. F. Hadley, Camden; A. W. Bailey, Atlantic City; Howard Ivins, Trenton; Chas. F. Adams, Hackensack.

Trustees: Chas. H. Church, one year; C. W. Perkins, two years; Frank P. McKinstry, three years; A. W. Atkinson, four years; Frank P. Eckings, five years.

Necrologist, Wallace McGeorge, 521 Broadway, Camden.

#### COMMITTEES.

Executive Committee: The President, the Vice-Presidents, the Recording Secretary, the Corresponding Secretary, the Treasurer.

Publication Committee: The Executive Committee.

Committee on Ethics: The Fellows and the Executive Committee.

Auditing Committee: Edward O. Cyphers, Belville; Arthur Wilkes, Irvington; R. W. Moister, Summit.

Legislative Committee: A. W. Atkinson, Trenton; V. A. H. Cornell, Trenton; Edward H. Baldwin, Newark; I. N. Griscom, Ocean City; F. W. Cornwell, Plainfield.

Registration and Statistics: C. F. Hadley, Camden; A. W. Atkinson, Trenton; Wallace McGeorge, Camden; R. F. Rabe, New York; L. E. Hetrick, Newark.

#### BUREAUS.

Materia Medica and Drug Proving: Rudolph F. Rabe, New York; Edward Rushmore, Plainfield; P. E. Krichbaum, Montclair; Francis McConaughy, Somerville; Wallace McGeorge, Camden.

Clinical Medicine and Pathology: E. T. Davis, Bound Brook; Carl H. Williams, Newark; Frank Jones, Camden; E. M. Easton, Newark; M. D. Youngman, Atlantic City.

Surgery and Gynecology: B. H. Garrison, Red Bank; Widmer E. Doremus, Arlington; B. H. B. Slegt, Newark; H. C. Reynolds, Passaic; J. Wyllis Hassler, Belmar.



Obstetrics: Eugene G. West, Orange; Nathan Thorne, Moorestown; S. D. Smalley, Newark; Edward S. Sheldon, Collingswood; L. N. Slaughter, Pitman.

Physical Therapeutics: Chas. F. Adams, Hackensack; A. W. Bailey, Atlantic City; J. H. Cooley, Plainfield; T. D. Blair, Plainfield; Joseph H. Bryan, Asbury Park.

Pedology: Florence E. Voorhees, Spring Lake Beach; V. A. H. Cornell, Trenton; A. W. Westney, Atlantic City; Edgar Clement, Haddonfield; Warren H. Smith, Newton.

Sanitary Science and Public Health: Allen Corson, Ocean City; W. R. Ward, Newark; J. T. Beckwith, Atlantic City; Duncan Campbell, Woodbury; H. R. Farringer, Mt. Holly.

Ophthalmology, Otology and Laryngology: Otis Stickney, Atlantic City; L. E. Hetrick, Newark; Howard Ivins, Trenton; W. F. Beggs, Newark; Clinton C. Straughn, Red Bank.

Homœopathic Philosophy: Ella Upham, Asbury Park; John Younglove, Plainfield; Frank P. Eckings, Paterson; A. W. Atkinson, Trenton; Arthur Weller, Orange.

#### DELEGATES.

Interstate Committees of A. I. H.: A. W. Bailey, Atlantic City (1913), C. H. Wintsch, Newark (1915).

New York State Homœopathic Medical Society: F. P. Eckings, Paterson; Justus H. Cooley, Plainfield.

Pennsylvania State Homœopathic Medical Society: Lee E. Griscom, Camden; Clarence Bartlett, Philadelphia.

West Jersey Homœopathic Medical Society: F. P. McKinstry, Washington; Edgar V. Moffatt, Orange.

Atlantic City Homœopathic Medical Society: Wm. T. Hiliard, Salem; H. H. Grace, Camden.

Essex County Homœopathic Medical Society: A. W. Atkinson, Trenton; C. W. Perkins, Princeton.

Monmouth County Homœopathic Medical Society: H. C. Garrison, Camden; Jacob M. Davis, Burlington.

Mercer County Homœopathic Medical Society: C. F. Hadley, Camden; W. W. Knowleton, Camden.

New Jersey State Sanitary Association: H. W. Foster, Montclair; Ralph Iszard, Haddonfield.

## EDITORIAL

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### A WARNING AGAINST FADS IN DIET.

IN view of the numerous dietetic fads that are in vogue at the present time, we are not surprised that the United States Department of Agriculture has recently issued a warning to the public in regard to accepting the advice of the so-called "diet experts" who seek to make monetary gain by advising particular systems of diet.

Some of these faddists insist that normal health can only be maintained upon a diet of raw food; some sing the praises of cereals, others of nuts, others of meat, others of fish, and, in fact, almost every substance that can be eaten at all has its particular advocate who considers it the *only* essential food in all the realm of nature. The only deduction we have been able to draw after reading a great deal of what has been written on this subject is that human beings may exist and, in individual instances at least, maintain a fair degree of health on almost any food. Because this is true in certain individuals, however, we are not warranted in the deduction that such a diet would be best for other individuals or for people in general. The bulk of human experience clearly shows that a man's chances of health are best when he eats with moderation of ordinary mixed diet, prepared in the usual ways.

One of the most peculiar of the methods of reasoning that prevail among food faddists is to cite the fact that certain animals, such as rabbits or muskrats, can thrive only on raw vegetable foods. Such animals, they state, do not get along well on cooked food and they draw the deduction that because rabbits cannot thrive on cooked foods, human beings should confine themselves to raw foods. Such reasoning has, of course, no value whatever, though to the average layman, who is ill-fitted to judge of such matters, it may seem very logical. As the report of the Board of the Department of Agriculture remarks: "Raw food is natural to rabbits and this is perhaps a fortunate provision of nature, because the average rabbit would

probably have a good deal of trouble lighting the fire, or a gas stove to cook the food; but it does not follow that man, who has proved cooked food wholesome by uncounted centuries of use, should give it up."

It is not to be supposed, however, that vegetables are the only substances that must be eaten raw. According to the many self-styled "dietetic experts," meat, fish and numerous other foods of animal origin, are also pronounced to have wonderful properties if taken in raw form. Just why this wide-spread advocacy of raw food has sprung up is not clear, unless it is to fill the demand for "something different." As far as any record of human experience goes, men have existed upon cooked foods. The value of cooking, especially in the case of vegetables, lies in the fact that it softens the food, breaks up the fibrous structure that envelopes the starches and other nutritive principles and renders innocuous pathogenic bacteria, spores of fungi, eggs of insects and other disease-producing substances that may adhere to vegetables in their crude state. It is a well-known fact that various forms of intestinal parasites and quite a number of infectious diseases are much more common among races who are accustomed to eat freely of the raw vegetables or raw meat.

Another prominent fad is the condemnation of meat as an article of diet. This idea has been popular with the public for two reasons. First, because there is a degree of truth in the statement that the average American family consumes too much meat, and, second, the increased cost of meat has necessitated a restriction in its use as a food because of economic reasons.

We believe, however, that it is possible to carry the restriction of meat in the ordinary healthy individual to an extent that is harmful rather than advantageous. Professor Gautier, in a recent lecture on the value of foodstuffs, expresses the opinion that vegetarianism in no way meets the requirements of modern life, and that, if adhered to strictly, it reduces the energy, weakens the will power and lessens the capacity for prompt decisions. Whether or not these statements can be accepted as entirely accurate, we are not in a position to decide, but it is a significant fact that the ruling nations of the world to-day are made up of races in whose diet meat has occupied a prominent place for centuries.

G. H. W.



**NEW SESSION OPENS AT HAHNEMANN.**

THE sixty-fifth annual session of the Hahnemann Medical College of Philadelphia, was opened on Monday evening, September 22d, by a few words of welcome from the Dean, Dr. Wm. B. Van Lennep, a short prayer by the Reverend Floyd Tomkins, D. D., and an address by Professor John E. James, Jr. In many respects this meeting was a memorable one, but interest centered chiefly in the announcement of the Dean, that "Old Hahnemann" opened this year with fifty new matriculates, an increase of about one hundred per cent. over the average number for some years past. While this of itself would be a matter of great satisfaction to all interested in the welfare of Homœopathy, it is particularly significant that this increase in students came despite the fact that new and rigid requirements have but recently been put in force by the State Board of Medical Education and Licensure.

We believe that several deductions can logically be drawn from this marked increase in the number of new matriculates. The first of these is that the high standard of medical education that has been attained in the Hahnemann Medical College of Philadelphia during the past two or three years is bound to attract an increasing number of properly qualified medical students. Men who contemplate entering upon the practice of medicine are beginning to realize that it is essential for them to become affiliated with an institution that gives them a practical and up-to-date medical education if they are to successfully pass the rigid requirements of the State Medical Boards and secure licenses to practice medicine. Of the members of the graduating class of 1913 who took the Pennsylvania examination in 1913, one hundred per cent. passed; a record equalled by only one other institution in this State and one of which every son of "Old Hahnemann" should be proud.

The second deduction is that a homœopathic institution is capable of maintaining its ground under present conditions even when under the supervision of a single state medical board composed largely of men of other schools of practice. Hahnemann has asked no special favors, nor has she received any. She has only asked a square deal and equal rights and, competing on this basis has demonstrated to the profession and to the public her fitness to equip men in a manner that has only been equalled by but one other medical institution in this State.

Third, there is in this increase of matriculates an indication that homœopathic institutions are again attracting each year a proportionately larger number of students. This increase in the number of students has not been limited to Hahnemann alone, and we are glad to note that some of our sister colleges can report an encouraging increase in their student body. This turn in the tide in the fortunes of Hahnemann and other homœopathic institutions has come at a very opportune time. It shows what can be accomplished if we put our shoulders to the wheel and work with interest and with zeal. Instead of being satisfied with what has been accomplished this year, it should only serve as an incentive to every homœopathic practitioner with whatever institution he may be affiliated, to put forth every effort to push the standard even higher next year. It has been demonstrated that we can meet the requirements of modern medical education better than the vast majority of old school institutions, that prospective students of medicine will be attracted to our institutions when we are fitted to give an up-to-date scientific course, and that there is no lack of interest in homœopathy and in homœopathic institutions, when they are prepared to fit men effectively for modern medical practice.

G. H. W.

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**AURUM IN OSTEOMYELITIS.**—In a series of cases recently reported in *The Homœopathic Recorder*, Dr. C. J. Veniot, of Bathurst Village, New Brunswick, dwells on the action of aurum in an involved case of osteomyelitis. An excellent result was gotten by the sixth potency. Previously, there had been prescribed by Dr. Veniot, mercurius which was, of course, indicated as the action of this medicine in infectional states is very closely allied to aurum. The aurum was given every hour and pain disappeared after the third dose; it returned four days after this; another dose of the gold put everything in order. The osteomyelitis had involved the tibia.

**CUPRUM METALLICUM.**—It has long been known that metallic copper in homœopathic attenuation has a marked effect in spasmodic states, especially when the same is more or less directly referable to the upper air passages. Dr. Purdon, in the *British Homœopathic Journal*, speaks concerning the curative action of cuprum metallicum in laryngismus stridulosa (spasmodic croup). He has had permanently good results with this remedy when using the 30th to 200th dynamization. Cuprum-metallicum has also proved of distinct value in severe griping and spasm about the region of the heart. It also produces in the healthy prover a confused head condition, accompanied by backache at the top of the sacrum.

## GLEANINGS

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THE DIAGNOSIS OF INTUSSUSCEPTION BY X-RAY.—Irving M. Snow and Marshall Clinton, Buffalo. *American Journal of Diseases of Children*, August, 1913. The authors report a case of intussusception in an infant of three months, in which the diagnosis was aided by the use of the X-rays. The patient was X-rayed after having had a bismuth emulsion injected into the rectum. The picture plainly shows the occlusion of the bowel due to the invagination. The authors believe this to be the first case in which a radiograph has aided in the diagnosis of the condition, and they advocate further trial of X-ray examination in cases of intussusception.

TREATMENT OF GASTROINTESTINAL HEMORRHAGE.—By I. Boas. *Berliner klinische Wochenschrift*, April 7, 1913. The large percentage of cases in which serious gastrointestinal hemorrhage is preceded by the appearance of occult blood is emphasized by the author. In his case of gastric cancer this sequence occurred in 94.5 per cent. Such occult bleeding should be dealt with as though it were a marked hemorrhage. The patient should remain in bed on a diet consisting of 3 or 4 liters (quarts) of milk, with Carlsbad water, with or without salt, until no occult blood can be detected for three or four days in succession. Where the disorder present is cancer, and visible hemorrhage takes place, the latter, though not often serious at any given time, is likely to continue for an indefinite period. If operative treatment is not possible, liquid food and eggs should constitute the chief elements of the diet.

Enlargement of the liver or spleen in conjunction with gastrointestinal hemorrhage should also suggest syphilis. If the Wassermann proves positive, excellent results from specific treatment may be obtained.

In severe gastrointestinal hemorrhage from whatever cause, the food allowance should be strictly limited to cold tea, ice-cold milk or egg-white jelly, taken regularly in very small quantities. Nutrient enemas are of little value. Normal saline solution introduced into the bowel by the drop method, however, is of great value. One liter should be given each day, and to it 15 drops of 1:1000 epinephrin solution may be added with advantage. An ice-bag may also be employed. In severe cases gelatin should be given, though its utility is doubtful. Rectal injections of calcium chlorid may be given. Where palpation shows that there are clots in the stomach and these are maintaining local irritation, the organ should be washed out with ice water.

In hemorrhage due to hemorrhoids, the author sets great stress on rectal injections of pure crystallized calcium chlorid. Given systematically such injections have proven so efficient in his hands that for some years



he has not had occasion to recommend operation to any hemorrhoid cases for bleeding alone.—*Monthly Cyclopedia and Medical Bulletin*.

THE INTELLECTUAL STANDARD OF DOCTORS.—There is not the slightest reason to believe that physicians are linguistically inferior to parsons or lawyers. The assertion that English doctors are inferior in general culture to their French and German brethren is entirely unwarranted by facts. It is true that many of the keenest minds of the nation are attracted to fields of activity which offer a better financial return. But fortunately many men of intellect are attracted to the profession by the interest of the work, and it would be strange indeed if medical men whose education is more elaborate and costly than that of any other class of the community should have a lower intellectual standard than that of other professional men. It is recorded by Boswell that Johnson "in general had a peculiar pleasure in the society of physicians." Sir James Paget, as is mentioned in his "Memoirs and Letters," sat one evening at that very select club, Grillion's, between Gladstone and Matthew Arnold. The talk turned on professions, and Gladstone said that medicine, steadily developing and improving, was the profession of the future. Arnold said he had been much impressed in America by the superiority of the doctors over the clergy and the lawyers. As regards classical culture in particular, that is becoming more and more the appanage of a highly specialized class. Members of Parliament no longer quote Latin, and the time is long past when, as Sydney Smith said, a false quantity in early life is a stumbling block in the career of a politician.—*British Medical Journal*.

AUTOSERUM THERAPY AND SUBCONJUNCTIVAL INJECTIONS.—Serum was removed from artificially formed blisters and injected subconjunctivally in various cases. Abscess of the cornea with hypopyon responded in three days, parenchymatous keratitis of tuberculous origin cleared up following this treatment. Cases of iritis, scrofulous keratitis, vernal conjunctivitis and sympathetic ophthalmia were all improved. However, Darier finds that antidiphtheritic serum has proven fully as efficacious, and believes that the subconjunctival injection is the effective agent. Serum is obtained in a more scientific manner by bleeding the patient, centrifugating and drawing off the fluid. The favorable action is attributed to the formation of a special vaccine, probably specific to the patient suffering, by overcoming the micro-organisms and combating their toxins.

A month later Darier after writing this article had two disappointing cases, one a sclerosing keratitis and the other tuberculous interstitial keratitis. This must not nullify the interesting observations of Rohmer, but increase reports upon these lines.—*A. Darier, Paris. La Clinique Ophthal.*

WILLIAM SPENCER, M. D.

RADIOACTIVE LENSES—THEIR ACTION UPON THE EYE AND VISION.—The radioactive lenses in a dioptric measure which corrects refraction defects at the same time, by incorporating radium in the silicates of the glass, gives the curative power of that element. The air space between the glass and eye is ionized and clinical experiments together with the electroscop of Professor Curie demonstrates the efficiency. (1) The activity of meta-

bolism is augmented. (2) The nutrition of the eye is increased. (3) The curative action upon the interior of the eye is increased. (4) The curative action upon the interior of the bulb has a beneficial action upon beginning cataract, choroiditis and retinochoroiditis. The visual power of myopes is materially benefited by easing the convergent forces, and asthenopic symptoms are relieved. Hypermetropes and presbyopes who have worn this glass affirm that they feel refreshed. External diseases which have been relieved by exposure to radium, as conjunctivitis and blepharitis, heal readily, and the prolonged treatments can be dispensed with. Of course the idea is rather new and much more experience is necessary before drawing positive conclusions.—*Precerutti, Turin. La Clinique Ophthalm.*

WILLIAM SPENCER, M. D.

**TOTAL CONGENITAL COLOR BLINDNESS.**—The subject when first seen was fourteen years old, and when seen again was twenty. In the intervals of six years the findings had suffered no change whatsoever. The patient had no hereditary stigmata, and was intellectually and physically normal. His parents were not blood relatives. His eyes presented no external anomaly except a slight horizontal nystagmus with a rotary tendency. In moderate light there was no photophobia, but in strong light yellow glasses were worn, and strong sunlight was distressing. His corrected vision was 1-3, when the test types were moderately illuminated; with strong illumination the vision was markedly less. The field was normal for form. Color sense totally absent. The different colors are distinguished according to their luminosity; all colors of the same shade are grouped together. No hemealopia present. The media are all clear, and the fundus, with the exception of a slight anomaly of the vessels and an intense pigmentation, normal.

Contonnet held to Parinaud's theory of "an anomaly of the cone retina," the rod retina being normal. As a microscopic examination of this anomaly has not been possible, one is forced to theorize. The clinical import is that were we to bear this anomaly in mind and to look for it in those who present congenital anomalies of vision, we would be more likely to find it oftener, i. e., we would oftener detect subjects who are "color blind without knowing it."—*A. Contonnet. Archives d'Ophthalmologie.*

WILLIAM SPENCER, M. D.

**HAS BLENORRHOEA NEONATORUM DECREASED?**—Under this title Credè-Hörder (Berlin) has published a critical examination of the actual facts relating to this disease. He says while it is true that in institutions one case only occurs among thousands of children, and while in consequence of proper treatment children are there protected against blindness, yet throughout the country, blindness in consequence of ophthalmia has decreased but very little. Sufficient attention and effort have not been directed to finding means whereby these good results in hospitals can be made to materialize among the people in general. A number of recently published articles have shown that we have thought entirely too optimistically about this disease. It appears that about 8 per cent. to 10 per cent. of blindness in Bavaria is caused by blenorrhoea. But if cases under ten

years are alone considered the percentage suddenly rises to 38 per cent. to 43 per cent.

An inquiry among thirty institutions for the blind in Germany has revealed the fact that 12.39 per cent. are blind from blenorrhoea. This is a sad state of affairs. Considered from an economic point of view the author found that the maintenance of such a case requires a yearly expenditure of about two hundred dollars. The expenditure required in a few years amounts to millions of dollars. Considering also the fact that these patients are not in any sense producers the yearly loss amounts to a vast sum. This estimate and the percentage above named include only those cases cared for in institutions, but besides them many more cases are cared for at home.

Before the introduction of the Credé method the percentage in hospitals was about 40 per cent., which gradually thereafter diminished to zero. Outside of hospitals, however, the percentage has remained with but little decrease.

The author, therefore, concludes that physicians should give less attention to the question of just what particular modification of silver salts are preferable in the treatment of a disease causing so great misery and economic loss, and should rather endeavor to bring about a compulsory use of some one of them in every case.—*Zentralbl. f. Gyn.* 1912—1503.

THEODORE J. GRAMM, M. D.

THE ACTION OF PITUITRIN.—Pituitrin as a therapeutic aid in obstetrics has evidently come to stay. Its action has been extensively studied, mainly clinically, and though the literature is extensive yet Malinowsky's article attracts attention because of its conciseness. He says pituitrin favors intestinal peristalsis, excites the motor activity of the bladder, and its action upon the heart and circulation resembles adrenalin but the contraction of the peripheral vessels from pituitrin causes a more constant and less intense increase of blood pressure lasting for a half hour or more. Upon the heart the action is to diminish its frequency and increase its force. Contrary to adrenalin it does not contract the renal vessels; after a transient contraction there is rather a dilatation, so that diuresis is increased. Its most useful action, however, is as a means of increasing the uterine contraction in the expulsive stage of labor. Here its effects are certain and prompt. The uterine contraction retains its physiological rhythmical character, and the intervals are shortened. There is a period when the contractions are so close together that they have been called stormy or tetanic, which continues for about eleven minutes. In the earliest periods of the first stage of labor and in primiparae with a dilatation only admitting two fingers with unruptured membranes and when the os is particularly rigid, a true tetanic condition may be induced. When the membranes are ruptured this tetanic contraction was not observed. A dose of 1 cm. is quite sufficient. Smaller doses have less effect. The action of the drug is observable in from three to seven minutes, irrespective of where the hypodermic injection was made. The action is continued for about one hour. The placental stage is not interfered with, and the placenta is spontaneously expelled. In heart diseases and kidney affections the preparation is contraindicated.—*Zentralbl. f. Gyn.* 1912—1425.

THEODORE J. GRAMM, M. D.



CARE OF THE NAVEL AT BIRTH.—Hirsch reports the results at the Freiburg clinic of treating the navel in 640 cases by applying a Kocher clamp immediately above the circular artery of the umbilicus and cutting off the cord immediately above the clamp. The latter remains in place for ten minutes, and the cord is then covered with some layers of sterile gauze over which the binder is applied. The fragment of cord came away as an average on the sixth day. In the heavier children a somewhat longer time was required, also in those slightly asphyxiated at birth and when the cord was rather large. In artificially fed children it came away on the seventh day. During the cold months of the year the completed process required longer time, while during the months of moderate heat the results were more favorable.—*Abstr. Zentralbl. f. Gyn.* 1912—1481.

THEODORE J. GRAMM, M. D.

INTERNAL SECRETION OF THE OVARY.—Schickele who has extensively studied the endometrium says that the histological findings both in the normal and pathological bleeding endometrium do not satisfactorily explain the hemorrhage. On the assumption that some chemical causes exist he made some experiments in blood coagulation with fluids expressed from human and animal organs. As a test preparation he used the plasma from the blood of geese, obtained by a peculiar process and which possessed the property of remaining uncoagulated for several days. The results of a large number of experiments were the expressed juices from uteri, ovaries, myomata, tubes and corpora lutea possess a pronounced action in delaying coagulation, which in comparison with the control experiments may differ by several hours. The effects were the same when the organs used were obtained from animals. On the contrary, a watery extract of these organs hastened coagulation. The substances retarding coagulation obtained from the uterus and ovaries the author classifies with substances like hirudin and for the present names them antithrombin. A similarly acting agent was found in menstrual blood. The author assumes, in view of the dependence of the uterus upon the ovarian function, that the source of antithrombin must be sought in the ovaries.

In another series of experiments the author has produced substances similar to those above named, and also by using boiling alcohol, and injected then into the veins of rabbits and then studied the blood pressure. In all cases the blood pressure declined materially. Adrenalin and pituitrin were able to prevent or remove this effect. Aqueous and cold alcoholic extracts had depressing effect upon the blood pressure. These substances under consideration seemed to act upon the peripheral vessels and upon the vessel wall itself. Chemically these substances are lipid. They seem to have some relation to the sexual function since they are not found in the ovaries of women after the climaxis. They are probably derivable from the granulosa cells and later from the lutein cells.—*Abstr. Zentralbl. f. Gyn.* 1912—1485.

THEODORE J. GRAMM, M. D.

## Monthly Retrospect

### OF HOMOEOPATHIC MATERIA MEDICA AND THERAPEUTICS

CONDUCTED BY DR. DONALD MACFARLAN  
PHILADELPHIA

**CUPRUM.**—The pathogenesis of copper appears in the third volume of "Hahnemann's Chronic Diseases." The neuro-muscular symptoms elicited by the provings are convulsions and cramps. The convulsions are most marked in the lower extremities. They often begin in the hands and feet and extend thence to the larger muscles. The cramps are violent with piercing, burning constrictive and shooting pains. The limbs may be rigid in the intervals between convulsions. There is also great weariness and weakness of the limbs. Increasing general weakness. Prostration. Convulsion alternating with collapse. Convulsions and cramps are the keynotes for the use of cuprum. They are the indications for its employment in cholera and choleraic diarrhoea, or any gastro-intestinal affection in which they are present. Convulsions accompanying the paroxysms of whooping cough call for it. It is one of the best remedies for the convulsions of teething and the carpopedal contractions of infancy. Convulsions following suppressed discharges or repressed eruptions. Spasmodic respiration and asthmatic attacks. Violent after pains. Cramps in the feet and legs from whatever cause.

In severe cases of poisoning there are attacks of deliriums with lucid intervals, the delirium being accompanied by fever and a full, quick, hard pulse. In chronic poisoning there are profound dejection and anxiety, a sad and miserable expression and extreme want of power in collecting thoughts. The most prominent emotional state is fear. Many cases of chorea brought on by a fright, have been cured by it. The disposition is malicious and morose. The headache is often severe and mostly frontal. There may be somnolence and semi-consciousness going on to coma with pale face, cheeks and eyes sunken, the lower jaw hanging down, the pupils abnormally dilated and insensitive to light. Other symptoms of the cerebro-spinal nerves are severe pressing pain in a straight line from the temples to the angle of the lower jaw, numbness of various parts, especially of the extremities, tearing and burning pain of superficial character and changing locality. Tremulous, shivering like an ague fit.

Cuprum depresses the heart. The provings show that it produces palpitation, precordial anxiety and pain. It has been found of great benefit in cases where a weak heart muscle exists with attacks of precordial pain like angina pectoris. The pulse may be hard, full and quick with fever, red and dry skin, but the more usual condition is for the pulse to be

small and contracted, whether quick or slow, and the skin cold and moist with subnormal temperature. The affinity of copper for hæmoglobin has suggested its use in anæmia, and it has been given in some cases with good result. Chlorosis from abuse of iron.

The respiratory symptoms of copper are all due to its action on the nervous and muscular apparatus concerned in respiration. They are frequent singultus, short, hurried, irregular breathing, obstinate hiccough, dyspnœa with laryngeal and bronchial spasm, paroxysms of violent cough without expectoration or physical signs and sharp, cramping pains in the chest. Its therapeutic use corresponds. It has been found useful in the paroxysms of asthma and in whooping cough, especially when there are convulsions. By the old school it is sometimes employed as an emetic in croup, when possibly a specific influence reinforces its emetic action.

Copper is excreted by the skin in cases of poisoning. The skin is cold, moist, clammy, even doughy, pale or slightly yellow. There may be much perspiration increased by the warmth of fire or bed. Petechiæ on the chest and arms have been noted, and in one case there were red, raised spots the size of sixpence, and covered with blisters. Dr. Hughes says: "A dilution of the acetate has given me quite a fresh power over chronic psoriasis and lepra. In nearly all cases there is more or less complete suppression of urine during the acute stage of poisoning; later the urine contains albumen and casts; in severe cases blood cells and hæmoglobin. If the irritation of the kidney is long continued secondary inflammation of the interstitial tissue and ultimately cirrhosis of the kidney results. Cuprum is indicated in the cramps and convulsions of uræmia. In the chronic poisoning of workmen a green line is observed on the teeth and a purple line on the margins of the gums. The workmen are liable to intermittent attacks of shivering, followed by profuse sweating, with possibly a short hot stage intervening between the two. *It has been observed that men employed in copper works have escaped cholera during epidemics in which it has been rampant in the neighborhood, and copper has been recommended in consequence as a prophylactic during epidemics of cholera.*

General prostration, fainting fits, coldness, paralysis of isolated muscles, cramps, convulsions, violence of muscular action alternating with weakness, and a mental condition of fear and anxiety are the leading symptoms calling for cuprum.—Chas. E. Wheeler, M. D., B. Sc., *The Homœopathic World*, London.

"THE LAW"—Quite recently, one of the most shining exemplars of the homœopathic practice in Great Britain, Dr. T. Miller Neatby, gave a most excellent address at Chalmers House which is deserving of the highest encomium. The subject of his address was "The Law," and he treated the same with admirable clearness and interest. In substance Dr. Neatby said:

"Well now, what are the advantages of this law of similars? The first advantage of all is that it is a law. A law is, in its own sphere, of universal application. A law is like a round of beef—it is cut and come again.

"It has been objected that homœopathy is an upstart, and some even



allege that it is disfigured by the objectionable characteristics of the *vaccinæ*. A therapeutic law is a law of Nature, and would it have been left for someone at the beginning of the nineteenth century to discover so tremendous a law? I do not think such reasoning very cogent. Indeed, it seems to me an obscurantist appeal to prejudice—a contention that would logically oppose a barrier to all scientific advance. But there is this much of truth in it, as it seems to me, that if this law be really a law it is so tremendous a law, a law touching so intimately all the life of all of us from the cradle to the grave, that it must surely have been foreshadowed in some fashion, in some place, at some epoch in the thousands of years that man has lived upon the earth. I think that would be a not unreasonable contention. It would accord with that saying of profound old-world wisdom, that “there is nothing new under the sun.” You know that Hippocrates, who flourished in the fifth century before Christ, is called the “father of medicine.” Well now, Hippocrates gives the following prescription for the cure of mania: ‘Give the patient a draught made from the root of mandrake in a smaller dose than is sufficient to induce mania.’ Mandragora is botanically akin to belladonna, stramonium and hyoscyamus, which are remedies that homœopaths at the present day use for mania. Now, Hippocrates, we are told, cured his old teacher Democritus of mania; so that the prescription I have quoted is likely to have been the fruit of his own experience in practice, in which case one may say that Hippocrates was the first homœopathic practitioner! Certainly Hippocrates got a glimpse of the great law. But the great law was re-discovered by Hahnemann entirely *de novo*; for whatever homœopathic ideas may have lurked in the medical traditions of the ages were as effectually buried under cartloads of ridiculous and often disgusting rubbish as seeds of corn, thousands of years old, have been hidden from the light in the swathings of Egyptian mummies, to revive and germinate in these latter days. Not only did Hahnemann re-discover the law, but by patient and prolonged experiment he placed it upon a secure basis.

“The eagerness with which many of our old school brethren, who have been sincere if somewhat prejudiced and misguided seekers after truth, have hailed the vaccine treatment of diseases is easily understood, and at the same time a little pathetic. At last they have found a law of cure. Tuberculin was their first vaccine, but the great beauty of this discovery was not that it was (roughly speaking) a cure for tuberculosis, but that it opened up a vista to which there were no limits save the limits of bacteriology. The law appeared to be applicable to all microbic diseases. Theoretically, wherever there was a bacterium, you could make a vaccine and heal the disease which the bacterium had caused. The old school never had a law before. No wonder they are enthusiastic. The curious thing is that the law that underlies the use of vaccines is homœopathy after all, but a homœopathy restricted to a certain large but limited class of diseases, viz., those that are due to the mischievous activities of microbes. But what I want you here especially to note is that this enthusiasm of the old school, an enthusiasm which they have never shown for anything else, is an enthusiasm for *law*. We see law everywhere in nature. We live under a ‘reign of law.’ To me at least it is inconceivable that, while there is what the apostle calls a ‘law of sin and

death'—I use theological terms, but we all admit the existence of a law of disease and decay—it is, I say, inconceivable to me that there should not also be, if we will only seek for it, a law of healing and repair.

"How different a law of cure is from the idea of specific remedies! And how superior a law of cure is! And how piercing the insight that discovered the law under the so-called 'specific!' For that was what actually happened. One of the few specifics that the old school has ever claimed to possess is quinine. Quinine is a specific for malaria, they said long ago. They said it in Hahnemann's day. But they did not know why it acted favorably on malarial patients. It is well known that Hahnemann was translating Cullen's *Materia Medica* when, being struck by the unsatisfactory character of Cullen's explanation of the cure of ague by cinchona bark, he suddenly conceived the idea of testing the effect of the bark upon a healthy individual. He accordingly took twice a day for several days a four-drachm dose of cinchona, and was struck to find that he reproduced in himself an astonishingly accurate picture of the symptoms of malaria. By an elaborate series of experiments upon himself and other healthy persons with various other drugs, he showed that the case of quinine was no 'erratic block' in the world of therapeutics, but was merely one illustration of a great far-reaching law.

"One great advantage of this law is that a homœopath, when confronted by some disease or form of illness which has not been described, or which for some reason or other he is not able accurately to diagnose, need never say, 'I am unable to prescribe a medicine for this disease; I do not know what it is.' The homœopathic physician should always do his very best to get to the bottom, the pathologic and pathogenetic bottom, of every case of disease that he treats. The pathology of a case will often immensely assist him; it may even be essential to correct treatment. Therefore, he must by no means neglect the resources of careful methods of physical examination and the resources of pathological and bacteriological laboratories. I will give you an instance. A man was suffering from sciatica. Several remedies in succession were given on the basis of the symptoms complained of, without any result. Then another physician came along, examined the rectum, found a large accumulation of constipated motions, and ordered some copious rectal injections. The bowel was emptied and the sciatica was cured. The sciatica in this case was not a disease, but simply a mechanical result of accumulated feces pressing on the sciatic nerve. But sometimes even with the conscientious use of every ancillary method that is at our disposal we are not able to diagnose the condition. Nevertheless we may be able to cure it. Such a case is analogous to the situation in which Hahnemann found himself in reference to cholera when that disease was raging in the East, and was approaching Europe. Hearing by report what the symptoms of this strange epidemic were, he predicted the success of camphor in its treatment, a prediction that was abundantly fulfilled. The success of homœopathy in its application to cholera is worth recalling at this juncture. During the last epidemic of cholera in London, that is, in 1853, a medical committee of the Board of Health was appointed in connection with the epidemic, and also a medical inspector of those hospitals that received cases of cholera. The statistics of the results of treatment were so

extraordinarily favorable to homœopathy that they were at first suppressed by the medical board, but the Government of the day required that they should be made public. They showed that under homœopathic treatment more than two thirds of the victims of cholera recovered, whereas in allopathic hospitals more than two thirds died! The medical inspector himself, Dr. McCloughlin, who was not himself 'either by education, by practice, or by principle a homœopathist,' said of the cases treated in the homœopathic hospitals, 'All I saw were true cases of Asiatic cholera, in the various stages of the disease, and I saw several cases that did well under the homœopathic treatment which, I have no hesitation in saying, would have sunk under the other.' He added, 'Were it the will of Providence to afflict me with cholera and to deprive me of the power of prescribing for myself, I would rather be in the hands of a homœopathic than an allopathic adviser.' The case of cholera shows that homœopathy was prepared for the treatment of an unfamiliar disease.

"Some time ago I had a case in my own practice of a continued fever. I never could make out what that fever was. The man had lived in America for a good part of his life, and I inclined to the belief that it was one of the low remittent fevers that are met with in some foreign parts. He never gave me any serious anxiety, or I should have sought another opinion. So I prescribed on a frank basis of symptomatology. He was well again in two or three weeks. It might be said, 'Perhaps he would have got well in any case, and perhaps just as soon.' That is quite possible. I am not quoting the case as a triumph of homœopathy. That would be irrational. My point is that, while I regretted not being able to arrive at a diagnosis, I was not in the least dismayed, because I had a therapeutic law which not wholly, but to a considerable extent, makes one independent of diagnosis. Thus I was hopeful, and the hopefulness of the doctor is often reflected in the hopefulness of the patient, a spirit which largely assists recovery.

"I do not want anyone to suppose for a moment that I undervalue the importance of thorough and accurate diagnosis. Homœopaths have from time to time erred in this respect. Their well-grounded confidence in the great homœopathic law and their eagerness to apply it have sometimes led them to a fatal disregard of diagnosis, and to a prolonged medical treatment of cases that required surgical interference. The great homœopathic law is probably the only law of curative drug action known to men (I lay emphasis on the word *law*), but it is not the only principle of treatment. Thus we may upon occasion require to summon the surgeon's aid, as for instance to treat a fracture, to remove a stone from a bladder or kidney, to open an abscess, or to excise a tumor.

"Now this brings me to the consideration of another of the advantages of treatment according to the law of similars. Why do a great many people come to our homœopathic hospital? A great many come in order to escape operation. They think that homœopathy supersedes the dreaded knife. Well now, this is partly true and partly untrue. A good many operations undertaken at the present day are not necessary if a man has an understanding grasp of homœopathic principles."



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## X-RAYS IN THE DIAGNOSIS OF DISEASES OF BONES AND JOINTS.

BY

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THE X-ray is daily yielding immense harvests of knowledge to the medical profession. Of all departments of medicine, surgery has benefitted most by the diagnostic uses of this ray. With it the diagnosis of bone diseases has become an exact science. Indeed, it may be said that modern bone surgery has been made possible because of the advent of the X-ray.

It is the purpose of this paper to indicate briefly the value of the X-ray in locating and differentiating bone and joint pathology, and to point out the characteristic radiographic signs which appear in the more common of these lesions and which may, therefore, be used as a guide.

No one realizes more than does the surgeon that correct diagnosis is half the victory in the battle with pathologic conditions. We possess in the X-ray a method of the greatest value in assisting us to accurately determine the various pathologic conditions of the bones and joints. With its aid we are able to obtain early as well as exact information following which definite therapeutic procedures can be undertaken, and therefore clinically favorable conditions brought about in a much shorter time than would otherwise be the case.

Many surgeons have maintained that the X-ray is not needed to diagnose many of these conditions. That may be true in some few bone cases which have advanced so far that he who runs may diagnose, but for general work the usual tests have proved unsatisfactory and therefore would suggest that some-

thing more was needed. The extra knowledge brought out by means of an X-ray examination is worth a great deal. It localizes the lesion; gives an exact idea of its size, depth and extent and consequently makes more accurate not only our diagnosis but what is often more important, our treatment and prognosis. Even though a practitioner of wide experience and great ability can make fairly accurate diagnosis in many of the bone diseases, the X-ray should always be used to confirm the ordinary opinion diagnosis. Such procedure offers confidence to the patient and also protection against a malpractice charge to the surgeon.

The X-ray is the most reliable method for determining bone pathology known to-day, and I predict that when the value of scientific radiography is thoroughly understood and appreciated, far less attention and weight will be given to other methods of diagnosing these lesions. A radiograph properly made and correctly interpreted is not only of diagnostic value, but it also gives important information for use in any operative procedure which may be contemplated. Often it is of value in determining whether to operate or not.

Like the microscope, the cystoscope and other diagnostic aids necessitating the use of delicate apparatus, the X-ray brings us information which takes much study to properly interpret. Indeed, the proper interpretation of a radiograph is more important than the taking of the picture. To properly interpret radiographs there is need of opinion from one who knows not only that pathologic shadows are present; how they differ from the normal; but also what particular disease they belong to. It must be admitted that to be able to do this work in a scientifically correct manner it is necessary that the operator become thoroughly educated and exceedingly expert by long practical service in this particular branch of surgical work. A novice should not be expected to have a high enough degree of skill to make his work competent. An experienced operator can infer much more on viewing an X-ray plate than is ordinarily inferred by those not conversant with the details of this subject. He can see and locate lesions which would not appear to the uninitiated.

The more we study the diagnostic qualities of the X-ray the wider becomes the field. At present it may be said that most of the bones can be diagnosticated by this method.

In the brief time which is allotted to this paper it would be

impossible to consider in detail all the particular things connected with such an extensive subject. I shall, therefore, only give an outline of the most important differential points under each pathologic condition. The opinions expressed are, naturally, largely from the viewpoint of the X-Rayologist. But remember, the X-Rayologist is in a position to see the work of many surgeons and he also is in a position to compare results often on the same patient; besides he often has the opportunity of seeing radiographically, cases "before and after" operation and therefore he is bound to learn some things which the surgeon does not meet often enough to become thoroughly familiar with. For the sake of brevity I shall treat the subject in a distinctly clinical way.

1. *Tuberculosis.* Tuberculosis of the bone is a common disease, especially in children. Because it does not, at the beginning, give rise to pronounced illness, the disease has usually made considerable progress before the patient's condition is finally properly diagnosed. The following radiographic signs are indicative of bone tuberculosis. The lesion in the bone does not present the same density as normal parts do; because of the loss of bone substance the shadows constituting the diseased area are indistinct and present a hazy, non-contrasty picture; the part occupied by the diseased area is so thin it seems to have been under exposed; the bone substance has shrunk when compared with a like healthy part; the ends of bones, especially the epiphyseal parts and joints are the favorite seat of this disease; there is swelling of the joint, but no swelling of the periosteum where it covers the lesion; in advanced cases sequestra form due to encapsulation of tuberculous foci and these are recognized by the irregular dark areas which present the same appearance as when a radiograph is made through a large quantity of adipose tissue. Tuberculosis may involve the synovial as well as the osseous tissues and usually both tissues are simultaneously affected when the patient consults us. But, of course, only the lesion affecting the bone may be diagnosed by the X-ray unless there is an externally accessible sinus which can be filled with bismuth or some other X-ray resisting material and thus prepared to show a shadow. Differentiation between this and other bone diseases is not difficult when other systemic signs and the history of the case are investigated.

2. *Syphilis.* Syphilis of the bone is another disease fre-



quently met with. It has more varieties of manifestations than any other bone disease. It may be congenital and involve only the periosteum; it may appear as an osteitis involving only the body of the bone; it may, as in the late stage of acquired syphilis, involve bone periosteum and also the soft tissues adjacent, i. e. the synovial membrane, tendons and muscles.

Gumma of the periosteum due to syphilis show in the early stages of the disease as irregular bowl-like bulgings in the periosteal region, causing the bone at this place to appear as though swollen and curved. The bone proper is always clearly outlined by a dark line indicating sclerosis, but the pathologic portion is less dense than the normal parts.

In the later stages, when the periosteum is destroyed it does not bulge, but appears as a rough, ragged, projecting surface with less density than the unaffected bony parts.

Congenital syphilis is recognized by a periostitis and sclerosis of the bones of the hand and foot. The metacarpal and metatarsal bones are most often affected.

Syphilitic osteitis appears in the radiograph as irregular roughened defects on the outer surface of the bone proper, i. e. between the outer bone surface and the periosteum. Usually when we have an osteitis a periostitis is also present. Due to the chemical changes in the bone substance the lesion offers more resistance to the ray than the normal part and therefore the diseased parts show denser than the healthy parts.

In cases where, in addition to the bone and periosteal involvement we also have soft tissue involvement, either primary or secondary, there are added to the above signs the typical "island tumor formation" which appears throughout the soft structures adjacent to the lesion in the bone. The "islands" show very clearly on the radiograph as rounded, isolated, dense masses. They are due to a sclerosis in the soft tissues adjacent to the periosteum and are most commonly found in muscles. Their density can be judged when I say that usually they cast a shadow in the radiograph of equal density to that of bone.

3. *Necrosis.* No matter what the cause, necrosis of the bone is readily recognized in the radiograph because of the destruction of the bone substance. Where the bone has been organically disintegrated there the resistance to the X-ray is absent and consequently such areas of necrosis show very clearly by contrast with the normal parts.

4. *Rickets.* Rickets is a disease more frequently over-

looked than any other bone trouble which children may develop. Ordinarily this disease can be diagnosed without the X-ray, but occasionally the radiograph is useful to clear up a questionable diagnosis which has been arrived at by other methods. Because of the deficiency of calcium in the bones, particularly at the epiphyses, where bone is being manufactured, the shadow casting qualities of the diseased parts are less than normal. The morbid process usually involves the medullary canal and the cartilagenous parts causing irregular enlargement of the ends of the bones. There is also a bending and marked deviation of the epiphyses and, when long bones are involved, also a bending of the bone shaft. Often one bone will be involved while other adjacent bones will be perfectly normal, i. e. in the leg the tibia may show all the above mentioned abnormalities while the fibula will be normal, thus making quite a contrasty picture.

5. *Scurvy*. Like rickets, scurvy can usually be diagnosed by ordinary methods, but still cases have been found in which the X-ray has been necessary to absolutely settle a doubtful diagnosis. Advanced cases of this disease develop sub-periosteal hemorrhage resulting in swellings which can be shown by the X-ray.

The periosteum bulges much as it does in syphilitic periostitis, but it is not so bowl-like nor even, and there are patches of dark and light areas throughout the lesions. The disease usually affects the lower extremity and is most commonly confounded with rheumatism.

6. *Periostitis*. As outlined under the heading of syphilis, periostitis, no matter what the cause, can be recognized radiographically by a bulging shadow on the external surface of bones. This shadow is lighter than the bone, but darker than the flesh parts. In early cases the raised shadow is homogeneous and indicates the extent of the accumulation of exudate. In old cases the outer surface of the periosteal shadow is smooth but the parts next to the bone are roughened, and, because of their greater density, due to sclerosis, cast a shadow here which is usually denser than the bone itself. These bulgings of the periosteum may be single as in felon, or they may be multiple as in syphilis. Periostitis of traumatic or syphilitic origin is very common and should be kept in mind in "rheumatic or neuralgic cases" (?) which fail to do well under prolonged drug treatment.

7. *Arthritis.* Radiographically we may diagnose rheumatoid, gouty, tubercular and deformans arthritis.

In the rheumatoid form the joint shadows resist the ray more than is normal because of the sclerosis of the synovial tissues. The articular cartilages are roughened because of the growth of new bone from these points. The ends of the bones, especially just above the epiphyseal line, become deformed. To differentiate from tuberculosis we find that rheumatoid arthritis is accompanied by redness and inflammation of the soft tissues as well as pain in the joint. Ankylosis is not complete.

In gouty arthritis the articular surfaces of the bones are most involved. The normal space between the articular surfaces is absent, i. e., the bones are so close together that it is often very difficult to tell where one ends and the others begin. The ends of the bones are always hypertrophied and there is more or less complete ankylosis.

In tubercular arthritis there is destruction of all the joint tissues and, therefore, reduced shadow casting qualities of these structures. The signs as previously given under tuberculosis are all present.

Arthritis deformans is not a disease per se, but may result after any of the above forms of the disease have become chronic. All arthritides, at some stage or other, show hypertrophy of the ends of the bones and when this condition is accompanied by complete ankylosis the name "deformans" is usually applied.

8. *Bone-cysts.* Bone-cysts are comparatively rare and it is well that this is so for it is a condition which is difficult to diagnose even with the help of the X-ray. In the early stages a cyst of the bone and sarcoma look alike radiographically. In the later stages the two diseases can be differentiated because a cyst, which forms within the bone, never leaves the bone, that is, the periosteum, and a thin bony covering always limit or confine the cystic mass, while a sarcoma, after forming within the bone, goes through the wall of the bone, the periosteum, and even into the soft tissues outside. The cavity of a bone-cyst may be filled with a fluid or semi-fluid mass and as such materials offer little resistance to the X-ray the tumor casts a lighter shadow than the healthy parts. If the cyst is large the bone will appear swollen and distended. A thin wall of bone of normal density always encloses the cyst mass which



presents the appearance of drops of oil of different size, on a watery surface.

9. *Deformities.* Whether congenital or acquired deformities seldom offer difficulties of diagnosis by ordinary methods, but even here the X-ray may often be used to advantage in not only locating the limits of the deformity, but also to give us an idea of its structural nature.

10. *Osteo Sarcoma.* Osteo-sarcoma usually involves the ends of long bones where it ordinarily begins in the body of the bone and goes outward through the periosteum. More rarely it begins as a periosteal lesion and travels inward. The diseased part casts a pale, indistinct shadow having angular as well as rounded darker bordered isolated spots within the thin bony shell which is very much distended—often three to four times the normal size of the bone. In cases where the disease is very far advanced the edges of the bone do not cast a clear shadow, but instead a rough, moth-eaten edge is shown. A condition which might be mistaken for sarcoma is myositis ossificans, also known as myosteoma. In this latter disease the shadows in the radiograph look much like sarcoma, except that the pathologic area is sharply outlined where it joins the bone. Clinically, it may also be noted that myositis is a very slow growing tumor when compared with sarcoma; the latter also is a very devitalizing and painful affection when compared with the former.

11. *Chondroma.* Osteo-chondroma is a disease which is found in long bones. Radiographically it simulates sarcoma; the shadows are the same, except that in chondroma the mass is usually very circular and grows out from the bone presenting the appearance as though the tumor, which casts a much lighter shadow than the bone proper, has been placed so its rounded edge just touches the periosteum. Often, especially in young persons, the circular tumor will be shown in the radiograph on top of the bone shadow, which appears perfectly normal, so that one views the bone through a circular film or blotch. Usually, also more than one bone is involved, while in sarcoma one bone only is involved. It should not be forgotten that chondromata often degenerate and become sarcomatous.

12. *Osteoma.* When an osteoma starts from the periosteum, i. e., outside of the bone, it is called an exostosis; when it begins on the interior of the bone it is called an enostosis. Both of these conditions present a picture quite similar to

sarcoma, except that the bone is not swollen or distended and also that the periosteum and soft structures outside the bone are not involved. These tumors are also very irregular in outline, show more marked differences in shadow casting qualities, are of very slow growth and, unless near active joints, usually are painless as compared with sarcoma.

13. *Osteo-myelitis.* Osteo-myelitis can be diagnosed by the X-ray only when it is far advanced. There must be decided destruction (necrosis) of the bone resulting in the formation of a cavity or a sequestrum, before the lesion can be made out on the plate. Where the bone had been destroyed by the pathologic process there its shadow casting qualities are reduced and such areas can be plainly outlined in the picture. The light necrosed area is shown plainly because it is enclosed by a dark wall which later is due to sclerosis of the bone at the place. The bone is also swollen and a periostitis is nearly always present. In old cases having discharging sinuses we may find the bones presenting the appearance as though fractured. This is due to the fact that bone, as fast as it becomes destroyed, is discharged through the sinus leaving a void space which looks like a fracture. Here I might also mention that osteo-myelitis is a common development following compound fracture.

From the foregoing, I think you must be convinced, and I know you will agree with me when I say, that in the diagnosis of bone and joint trouble any surgeon who has not brought to his assistance the services of the X-ray has failed alike in his duty to himself and to his patient. Unquestionably the surgeon who desires to have the best results in his diagnostic and operative work must appreciate the usefulness of the X-ray. It will make many things clear which otherwise might remain hidden. The question of proper treatment we must all admit is dependent upon proper diagnosis. Temporizing treatment, expectant treatment, can be wiped off the boards if the X-ray is used more frequently. At present, in experienced hands the making of a radiograph is not a hazardous operation and therefore no one need fear of exposure to this diagnostic aid.

**SOME HINTS TO THE GENERAL PRACTITIONER ON THE SUBJECT OF  
ACCESSORY SINUS SUPPURATION.**

BY

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(Read before the New Castle County Homœopathic Medical Society, January, 1913.)

FIFTEEN or twenty years ago accessory sinus suppuration, because of its apparent rarity, might not have been considered a popular subject for a paper before a general society. Since then, however, the work of Zuckerkandl on the anatomy of the sinuses, and of Hajek on the pathology and diagnosis of accessory sinus diseases, has so increased our knowledge of the subject that we are now better able to recognize these conditions and the frequency with which they occur.

Concerning the frequency of sinus diseases, I feel safe in saying that practically every adult has suffered one or more attacks of some form of sinus disease; while it is not a rare occurrence for Rhinologists to find an individual with practically all sinuses affected on one or both sides.

My object shall be to present the subject to you in the plainest manner possible, avoiding any attempt at being over technical.

To begin with we must have some idea of the anatomy. I shall therefore make use of the wet specimens, trusting that I can demonstrate more from these in a few minutes than I could possibly describe without them in a decidedly longer period of time. The accessory sinuses are air-containing, mucous membrane-lined cavities of varying sizes, all communicating with the nasal chambers by small openings. Occasionally a sinus may have more than one opening (osteum) as for instance in the case of the Antrum of Highmore or better named, the maxillary sinus.

If we should count all of them we might truthfully say that the number of sinuses is indefinite; however, if we count them according to the number of outlets or ostes, there are five on each side. For instance, the so-called anterior ethmoid cells is really one sinus subdivided into a number of smaller cells, but all communicating or emptying through one common opening (osteum) into the middle nasal cavity. The same may be said of the posterior ethmoid cells. The knowledge of the



arrangement of these secondary pockets is unimportant as compared with a knowledge of the location of their ostea.

The accessory sinuses are arranged in two sets according to the location of their ostea. We have an anterior set which comprises the frontal, maxillary and anterior ethmoidal and a posterior set which comprises the posterior ethmoidal and sphenoidal. The ostea of the anterior set of sinuses open into the middle meatus; that is the space between the external surface of the middle turbinate and the lateral wall of the nose and discharges from them tends to flow anteriorly. The ostea of the posterior set of sinuses open into the recessus spheno-ethmoidalis or superior meatus, that is the space above and behind the insertion of the middle turbinate, therefore discharges from the posterior sinuses may be seen by anterior rhinoscopic examination between the middle turbinate and the septum or posteriorly running down the posterior or lateral wall of the pharynx.

The physiology of the sinuses is still an unsettled problem. At one time they were thought to act as resonators in the production of voice, but the method by which they are developed, i. e., resorption of superfluous bone with the simultaneous invagination of the mucous membrane into the spaces thus created would suggest that they are present primarily for the purpose of lightening the weight of the skull.

*Clinical Pathology.* From the fact that the sinuses are in direct communication with and really form a part of the upper respiratory tract we are not surprised to find them sharing in the pathologic conditions involving the mucous membranes of the nasal cavities proper.

For instance, "colds in the head" and surface spreading infections, typical of which is influenza, do not halt right at the orifice of a sinus; they spread, rather, into the sinus, involving it in the same process. If the orifice is narrow to begin with, it is still further narrowed by the concomitant swelling of the mucous membrane about it, resulting in some cases in occlusion. The products of inflammation (discharges) within the sinus, not finding a free exit, accumulate and eventually cause hydrostatic pressure within the sinus, giving rise to an unpleasant sensation of fulness and pain. Under such conditions more advanced pathologic changes are threatened.

In the manner above described acute suppuration of a sinus

may develop early in the course of an acute infection of the nasal mucous membrane; however, this is rather exceptional. More frequently acute sinus suppuration develops *later*, after the acute rhinitis has apparently subsided. I do not mean to imply that the sinus has been normal during the interim between the onset of the acute rhinitis and the development of the acute sinus suppuration (Empyema). On the contrary the sinus has been involved from the very onset of the rhinitis or very shortly thereafter but to no appreciable extent, noticeable to the patient or, often, the family physician.

In fact with every cold in the head where the patient suffers a heavy feeling or sense of pressure at the root of the nose, in the supraorbital region or in the cheeks, there is congestion of the sinus with swelling of the mucous membrane and hypersecretion corresponding to the location of the discomfiture.

*Diagnosis.* The history tells us of a preceding "*cold in the head*" in influenza. *Febrile symptoms* are generally present, temperature varying from 99 to 102 or higher in all recent cases; absent in chronic cases unless there be present an acute exacerbation. *Periodic discharge* from the nose, either anteriorly or posteriorly. More often *unilateral*, since acute sinusitis is rarely bilateral. Concerning the periodicity of the discharge I may say that it is quite typical for the discharge to show itself a short time after arising and continue for some hours after. Though I mention the most frequent behavior of the discharge it does not always behave so; on the other hand, should it do so it is a positive sign of acute suppuration.

Quite contrary to what has been said above, some of the most aggravated cases, suffering the greatest pain present *no discharge* whatever from the fact that the discharges are completely locked in the sinus by the absolute closure of its ostium.

*Subjective Sensation of Foetid Odor.* The patient is conscious of an offensive odor within the nose which is so apparent to him that he believes others can detect it too and is gratified by the physician informing him that it is not objective. Though this symptom is a strongly positive one when present, its absence does not prove that the patient is free of sinus trouble.

*Stiffness of One Side of the Nose* corresponding to that of the sinus affected, when of recent origin is a quite constant symptom. It is due to the presence of inflammatory oedema of the nasal mucous membrane in the region of the ostium of the sinus affected.

*Pain*, located usually at the site of the sinus affected, in exceptional cases referred to other parts. The pain may be dull or heavy in character, or it may be quite lancinating. It is more liable to be dull or heavy in character when the cavity is full of pus. After recent drainage, especially aided by blowing the nose, it is quite sharp for a brief period. Again it is quite sharp when an exposed nerve within the cavity is involved with the inflammation, for instance the middle branch of the fifth nerve in the maxillary sinus. Referred pains are occasionally met with and for the time being may deceive the specialist as to the location of the sinus affected.

*Tenderness* of the walls of the affected sinus is a very constant symptom in acute and subacute cases of empyema. The symptom is elicited by deep pressure or finger percussion. In the case of the frontal sinus the exact outline of the cavity may frequently be determined by this sign.

*Swelling Over the External Surface* of the sinus walls, although not a constant symptom, is of value when present. The swelling may be intermittent or progressive. It may or may not be associated with increased redness of the skin. The swelling is due primarily to a periosteal congestion or inflammation on the external surface of the bone; which periosteum is more or less involved in cases of severe inflammation of the muco-periosteum lining the cavity, because of the fact that veins and lymphatic vessels communicate between the two periosteal layers (inner and outer). A progressive red colored swelling suggests a sub-periosteal abscess and possible perforation.

Besides the symptoms and signs thus far outlined there are others of even greater value to us in diagnosis, requiring, however, closer inspection. For fear of leading you into a too intricate and uninteresting a field, I will speak only of a few of the more salient points with which a general practitioner should be more or less familiar.

Recalling what has already been said of the anatomy of the sinuses and pathology of sinus suppuration, we should expect to find an acute *swelling of the nasal mucous membrane in the region of the ostium of the affected sinus*. For instance, in case of suppuration in one or more of the anterior set of sinuses we see a *puffy, red swelling* on the lateral aspect of the middle turbinate due to the inflammatory oedema already mentioned. In fact the mucous membrane of the whole middle meatus is



similarly swollen, but more or less concealed by the swelling of the middle turbinate. This sign is extremely important. In the case of the posterior set of sinuses the local inflammatory oedema can be recognized by posterior rhinoscopy.

The next important sign is the presence of *pus* or *muco-pus* issuing, in the case of suppuration from one of the anterior set of sinuses, from the middle meatus or *lateralward of the middle turbinate*; while in case of suppuration of one of the posterior set of sinuses, from the superior meatus or *Medianward of the middle turbinate* (the fissure olfactorius).

Furthermore in suppuration of one of the posterior sinuses the pus may be seen to trickle down the walls of the pharynx from the recessus spheno-ethmoidalis by posterior rhinoscopy. My opinion is that posterior rhinoscopy is more difficult than anterior and no more definite in its results.

The positive finding of pus issuing from the osteum of a sinus, positively establishes the diagnosis of suppuration of that sinus; but the absence of pus does not prove the non-existence of sinus suppuration for the reasons (a) that the sinus may have been recently drained, or (b) the osteum so tightly closed by inflammatory oedema about it that the exit of pus is prevented (a locked up empyema). Every case of apparently locked up empyema is not really so, for many of these may be unlocked, so to speak, by the free application of some powerful shrinking solution, to wit: 20 per cent. cocaine solution containing a small percentage of adrenalin. A mixture, by the way, that I would suggest being used (of course cautiously) by the physician in charge of such cases. It not only aids us in the examination of the nose, but acts therapeutically in opening up a way for drainage.

The differentiation of one sinus suppuration from another belonging to the one set is rather too much to burden you with in one evening, besides lavage of each cell separately for diagnostic purposes is a task too great to expect of any but the specialist, accordingly with your permission a description of this feature will be omitted.

After having established the diagnosis of sinus suppuration and locating it in one or more cells of the anterior or posterior group, what is the family physician to do? In the first place, if the case is a very recent one and the temperature not above 100, and there are no other vital symptoms, do not worry over much, since a very large percentage will recover whether you treat them or not, however, the chance of a recovery is more

favorable and is likely to occur quicker with those under treatment than those not treated. There is a small per cent of sinus suppurations that will, for certain reasons, persist in spite of the care and treatment that you are able to give. These are the cases you will be compelled to refer to the specialist.

The *treatment* that you are warranted in carrying out consists in *putting the patient to rest* in the position most comfortable to him. He will usually select the position best suited to drain the sinus affected without knowing why. Not infrequently he prefers a sitting posture; in which event it would be better not to compel him to lie down. The patient's *room should be well ventilated*, of even temperature and the air should neither be too dry nor too moist, but better moist than dry. *Inhalation of hot moist vapors* containing compound tincture of benzoin at 10 minutes duration repeated every hour or so, frequently relieves the congestion and swelling of the nasal mucous membrane. *Local application of 20 per cent. cocaine* or cocaine and adrenalin to the region of the sinus for the purpose of shrinking the mucous membrane about the ostium.

Internal administration of belladonna tincture in drop doses. aconite, apis, arsenic, hepar, gelsemium and sanguinaria are among some of the more popular remedies with me. Aspirin in 15 grain doses followed by large draughts of hot milk or hot lemonade at bed time has acted well in some cases in my experience. Any remedy that may fit the totality of symptoms should be prescribed, but withal cases do occur where nothing taken internally seems to benefit the patient. It is not the fault of the remedy. In such cases upon close examination it will be found that a pre-existing nasal deformity or other mechanical or pathologic condition has so complicated the case that nothing short of surgical intervention will effect a cure.

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CONDITION OF NOSE, THROAT AND EAR AS FACTOR IN EXCEPTIONAL DEVELOPMENT.—O. Glogau bases his conclusions on a study of exceptional children in Herbart Hall. He found nasal obstruction with or without adenoids and tonsils present in both the advanced and the backward child. On the other hand, defects in the sound-conducting and sound-perceiving apparatus resulting in decreased hearing-power was only found in the backward children; in fact, the advanced type showed over-acute audition. This latter fact Glogau advances as a possible explanation of the musical prodigy. The function of the static apparatus of the labyrinth was found to be markedly impaired in the backward child, while in the exceptionally bright child an over-irritability was noted.—*American Journal of Diseases of Children*.

## INSTRUCTION IN PHYSICAL THERAPEUTICS.

BY

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HEARTILY endorsing the remarks of my immediate predecessor, Dr. Emil H. Grubbé, on the subject of physical therapeutics (The Crime against Physical Therapeutics, *Journal of A. I. H.*, July, 1912); it is the desire of your chairman to offer some concrete plan relative to what, in his experience, will prove adequate instruction in this growing and important branch of medical study. This plan is based upon present developments and will permit of expansion in the newer branches of medical science as they develop.

It is also desired at this time to express the conviction that a curriculum involving the subject of physical therapeutics can best be outlined by those who have had experience in these branches and that it is improper and savoring of effrontery for surgeons or teachers of clinical medicine to assume to dictate hours for the study of physical therapeutics when their own knowledge upon the subject is known to be entirely superficial.

Electrotherapy, Roentgenology and allied physical measures have, during the past decade become specialties in medicine and must be so considered with as much justification as are the subjects of surgery, ophthalmology and kindred branches.

The "Model Curriculum," having the endorsement of the American Medical Association comprising a report of a committee of one hundred leading educators of the United States and Canada, assumes to suggest a scheme for instruction in "non-pharmaceutical therapeutics."

The report of this committee reads as follows:

"The committee is of the opinion that didactic instruction in the general principles, effects and indications of non-pharmaceutical therapeutic measures—including diet, practical hygiene, massage, exercise, baths, electricity, X-rays, phototherapy, thermotherapy, balneology, climatology and psychotherapy, should for the present be introduced systematically and adequately in the didactic course on general therapeutics, and incidentally in the clinical courses as occasion arises. There



should, however, be a demonstration course in which small sections of students are taught the actual applications of the physical measures, as also such matters as enemata, position, cupping, venesection, saline infusion, immobilization, counter-irritation and similar details in the practical management of the patient.

"This should occupy 10-30 hours, mean, 10 hours, and be placed in the early part of the third year. The department of therapeutics should also secure the co-operation of all the clinical departments so that the instructors charged with the dispensary and ward work will actively secure to the students under proper supervision the greatest possible opportunities for the practical application of therapeutic measures, pharmaceutical, as well as non-pharmaceutical."

To further quote this committee: Non-pharmaceutical therapeutics is divided into the following departments:

"(a) Hydrotherapy.

"(b) Climatology.

"(c) Dietetics.

"(d) Electro-therapeutics (X-ray is presumably classed here).

"(e) Psychotherapeutics.

"(f) Other physical and physiological measures."

Questions suggested by the chairman of above committee: "These subjects seem to be taught so *unsystematically* at the present time that it seems superfluous to propose specific questions. I hope the sub-committee will prepare a comprehensive report on how these matters should be arranged."

#### DISCUSSION BY DR. HALSEY OF THE ABOVE COMMITTEE.

"Non-pharmaceutical therapeutics should be or best can be taken up after the student has finished his work on drug pharmacology and after he has begun to acquire some knowledge of pathology, general and special, and also some knowledge of clinical subjects. Such a course should, in the reporter's opinion, come during the first half of the third year.

"*Thirty hours* of lectures are probably enough for the theoretical discussion and demonstration of the general principles of diet, massage, exercise, baths, electricity, with brief mention of X-rays, phototherapy, and thermotherapy.

"This course should include instruction in such things as

enemata, position, cupping, venesection, transfusion or infusion, immobilization, etc.

"During it the chief stress should be laid on methods of carrying out these procedures and the mode and extent of their action.

"Indications should be discussed but briefly during these lectures, as these may be more properly taken up during the course on systematic therapeutics, later in the curriculum. Toward the end of the fourth year, seems to the reporter, to be the proper time to take up psychotherapy, balneology and climatology. (These latter two, in practice, we all know to be often modified psychotherapy.) (sic.)

"It is especially to be emphasized that during the actual work in the ward and O. P. D., non-pharmaceutical therapeutics should be taught and practiced, as only thus will the students actually learn how to apply such measures and to appreciate their importance and value. In this work every clinical teacher in medicine, surgery, gynecology and obstetrics, as well as in many of the other clinical departments should be required or urged to take not only an approving interest but also an active part." (Thus reports Dr. Halsey.)

The names of the committee having charge of the report on non-pharmaceutical therapeutics are as follows: Sollman, Abel, Capps, Edsall, Edmunds, Halsey, Lefevre, Long, MacNider and Osborne.

Not one of these eminent physicians appears in medical literature as an author in physical therapeutics nor are their names familiar in the literature of hydrotherapy, electrotherapeutics or X-rays. How can men who are not teachers or do not ostensibly possess special knowledge on subjects which they are reporting upon be expected to do full justice to the points at issue?

The whole conclusions must perforce be indefinite and faulty and the number of hours assigned mere guesswork. Taking the maximum number of hours assigned—30 hours—and dividing same by the subjects to be taught (hydrotherapy, climatology, dietetics, electrotherapeutics—including, presumably Roentgenology, psychotherapy and other physical measures) will give five lectures for each; leaving out dietetics which in some colleges is taught in connection with hygiene, *six lectures* is the average time assigned for each subject.

The myopic physician who endorses such a proposition has

not the slightest conception of the scope of these subjects if he assumes that a third or fourth year student can assimilate the principles of these branches of medicine in this short time, much less acquire any practical knowledge of the technic involved, in the application of same. To teach the growing and important subject of electrotherapy requires fully thirty hours alone. To attempt to learn something about the "X-rays" within a few hours, without subsequent danger of law-suits for malpractice, is tempting fate.

Assuming that X-ray technic requires the services of specially trained men, it is nevertheless imperative that *all physicians* have at least a working knowledge of the value of Roentgen rays in diagnosis, as well as a conception of their scope in therapeutics. This knowledge cannot be acquired in less than twenty demonstrations and lectures and a subsequent practical clinic service is essential for a successful and safe technic. The remarkable properties of radium and other radio-active compounds also require at least three or four lectures and demonstrations for intelligent exposition of their medical value.

The practical acquisition of the value of hydrotherapy in disease requires clinical and didactic instruction of a number of weeks' duration. To attempt to cover this subject in six lectures or demonstrations would be a farce and would cause the father of modern hydrotherapeutics, Professor Winternitz, to accuse the profession which sanctions such action as ill-advised or ignorant.

The whole report of the committee on "Non-pharmaceutical Therapeutics" is subject to severe criticism as it clearly shows a lack of intimate acquaintance with the subject and the consequent deductions, recommendations and conclusions cannot be accepted or approved of without amendment or material correction.

It seems to your chairman to be distinctly discreditable for this committee of the A. M. A. to permit publication of this report, for a careful analysis of same by anyone familiar with European clinical instruction promptly stamps it as faulty and therefore of but little value.

It is easier to criticise, however, than to construct; easier to detract than to add, and the critic should at all times be prepared for adverse opinion of his own views.

Your chairman has had practical experience in teaching the principles of physical therapeutics for over twelve years, and



welcomes criticism on the following scheme for adequate training in physical therapeutics which his experience suggests as desirable.

The subject itself should be taught in the fourth or fifth years of college when the student has absorbed the principles of general medicine and diagnosis and will appreciate the special points of diagnosis and therapeutics involved in these newer branches of medicine. Sophomores and juniors are not qualified to assimilate these studies.

A plan for the curriculum would comprise:

I. *Hydro and Thermotherapy* requires 10-15 lectures and coincident clinical demonstrations require fully as much time.

The technic of baths, packs, compresses, douches, irrigations, the application of heat and cold and the practical demonstration in special conditions certainly require 10-15 hours alone.

II. *Climatology, Balneology and Crounotherapy* require for superficial consideration from 8-12 lectures.

III. *Dietetics* with special emphasis on various diseases cannot adequately be given under ten hours and deserves many more.

IV. *Electro-therapeutics* includes galvanism, faradism, sinusoidal, static electricity, high frequency electricity (including fulguration and thermo-penetration).

To attempt to even gain a smattering of the physics, nomenclature and practical application of the various currents requires from 30 to 40 hours; therapeutic indications and familiarity with the technic fully as many hours additional.

V. *Roentgenology*: This growing subject requires adequate training in diagnosis as well as in therapeutics and should receive fully thirty hours of instruction. A post-graduate course in the clinics of Berlin or Vienna requires six weeks of daily instruction.

VI. *Phototherapy*, including mention of the Finsen ray, helio-therapy, ultra-violet, high candlepower rays, etc., can be explained and demonstrated in a few lectures, from 2-4 hours, and the technic mastered rapidly.

VII. *Kinesitherapy*, including exercises, massage, physical culture, Swedish movements, Zander exercises and Osteopathic philosophy and practical manipulations should consume from 20-30 hours.

VIII. *Psychotherapy*. This subject requires at least twelve

didactic lectures (from personal experience) and many practical demonstrations of the technic of suggestive therapeutics and can properly be given in connection with the chair of mental and nervous diseases as coming within its special province.

#### RESUME.

- I. Hydro-thermotherapy, 20-30 hours.
- II. Climatology, etc., 8-12 hours.
- III. Dietetics (preferably taught in connection with hygiene and omitted here).
- IV. Electro-therapeutics, 30-40 hours.
- V. Roentgenology, 30-40 hours.
- VI. Phototherapy, 2-4 hours.
- VII. Kinesitherapy, 20-30 hours.
- VIII. Psychotherapy (referred to mental and nervous diseases and omitted here).

These figures, 110 hours minimum, 156 hours maximum, are based upon a decade's practical experience and are not the dogmatic expression of teachers of allied branches of medicine. Proficiency in the branches enumerated requires subsequent post-graduate study and practical clinical experience and collateral study and reading of current literature.

Appreciating the fact that the public no longer worships at the shrine of drug therapeutics but is particularly partial to physical method of cure such as climatology, hydrotherapy, mechanical measures and electricity in its various forms, that portion of medical men who neglect to become conversant or proficient with these various branches, deliberately court a loss of influence and practice for it is only a question of time when the demonstrable truths of physical therapeutics will become public property.

As president of this Society I deem it my duty to sound a note of warning to such physicians who deny or minimize the importance of physical therapeutics and request them to give the subject some study, commensurate with its increasing importance.

## Transactions of the Homoeopathic Medical Society of the State of Pennsylvania.

### BUREAU OF SURGERY

#### CHRONIC INTUSSUSCEPTION, WITH THE REPORT OF A CASE.

BY

J. D. ELLIOTT, M. D., PHILADELPHIA.

CHRONIC intussusception while not a common lesion, deserves careful consideration in obscure abdominal diseases. In many instances an exact diagnosis can not be reached, but when the possibility of this condition is borne in mind and operation not too long delayed, the prognosis is good. Without surgical intervention a cure can only take place by nature reducing the invaginated gut, a rare possibility, or by a sloughing away of the intussusceptum, which is attended by a mortality rate of about 80 per cent. and is frequently followed by a stricture in those patients who survive. Mechanical measures, as massage or distention of the intestine with air or water, have at last been discarded on account of their dangers and inefficiency. Therefore, laparotomy is always indicated and further procedure, such as reduction by combined expression and contraction, resection, enterostomy, etc., must be determined by the general and local conditions.

When an intussusception has existed for two weeks it can be classified as chronic and that it can persist for a much longer period has been shown by reports of cases of over a year's standing. It may have no apparent cause or it may be secondary to tumors, usually a benign polypus, ulceration, foreign bodies, a patent Meckel's diverticulum, or it may follow trauma.

The pathologic lesions in the intestine vary; in one patient, who was treated for over a year for dysentery, no gross changes were discernible at autopsy. However, sooner or later adhesions usually form with more or less constriction of the lumen, the walls become oedematous or ulcerated, and during an acute attack, peritonitis or gangrene may supervene. One case has been recorded in which the obstruction was complete but the



faecal flow was sidetracked by a fistula between two loops of neighboring gut.

The symptomatology is so variable that in the large majority of cases the proper diagnosis has been disclosed at operation or autopsy. As it usually occurs in adult life more diseases must be considered than in the acute cases met with in young children, but an adult can give more subjective symptoms and the urgency of immediate diagnosis is not so great, so that at least a tentative diagnosis should be possible after careful study.

The previous history is of little benefit as the symptoms usually begin with a sudden pain, though milder attacks may have preceded it for some time. The characteristic pain is severe and paroxysmal, the paroxysms being brought on by anything which increases peristalsis. The intermissions are usually from a few hours to several days and during them the patient often feels perfectly well. As adhesions form these respites become shorter, and a duller, continuous pain is often present between acute attacks.

Nausea and vomiting are rarely absent, the vomitus occasionally contains blood, in one instance two severe hemorrhages occurred, but it is usually composed of the stomach contents and later mixed with bile.

The condition of the bowels is about equally divided between constipation and diarrhœa, the higher the intussusception the greater being the tendency to constipation. In a few cases the two may alternate and in several reports the bowel movements were normal. Tenesmus is ordinarily present when the stools are loose. Blood, usually accompanied by mucus, lying in the rectum or mixed with the faeces is of the greatest moment, but its absence is not so important, for in a fair percentage of cases it can not be grossly demonstrated. A rectal examination is indicated not only to seek hemorrhage, but also to see if the apex of the intussusception can be felt or protrudes from the anus. While this should make the diagnosis conclusive, a number of unfortunate mistakes have been made and the intestine divided under the erroneous belief that it was a tumor or prolapsus.

Such symptoms as loss of appetite, exhaustion, weak pulse, anemia, rapid emaciation, while not of themselves diagnostic, help to round out the symptom complex and should not lead to a diagnosis of tuberculosis or malignant disease. The ab-

sence of fever may be of considerable aid in helping to differentiate this condition from some of the acute inflammations.

General abdominal distention is usually not marked, but local distention, often accompanied by an area of flattening and retraction, due to the absence of intestine from its normal location, is of distinct diagnostic aid. Absence of rigidity of the muscles and general tenderness are the rule, though localized tenderness, often appearing late, may be met.

The symptom of greatest value is a tumor and this will be present in at least 90 per cent. of the cases, although, occasionally, an anæsthetic may be necessary to disclose it. The location will depend upon the variety of the intussusception, hence it is most frequently found in the right iliac fossa, though it may be in any part of the abdomen from the pelvis to the under surface of the liver. Similarly, the size and shape will depend upon the part and the amount of bowel involved, often small and rounded in enteric and large and sausage-shaped in the entero-colic variety. Generally it can be well outlined, at least its major portion, while its consistency varies from a firm to a mushy feeling, and it may be freely movable or only slightly so, depending upon the amount of free mesentery. When such a tumor can be definitely shown to change its shape, size and position or to disappear and reappear, an intussusception can be almost certainly diagnosed.

On account of the paucity of literature and the small amount of space devoted to this subject in our standard systems of surgery, the report of such a case follows:

Mrs. E. L. S., 47 years, widow. Was seen in consultation with Dr. G. Chapin Jenkins on March 30, 1913. Previous history in reference to gastro-intestinal tract was negative. Present illness began last November with sudden, very severe gripping pains in the upper abdomen. These were paroxysmal in character and accompanied by much nausea, vomiting and diarrhoea. No blood was noticed in the vomitus, but it was present in the stools. The gastric symptoms lasted for two days and the abdominal pain and diarrhoea continued for several days longer.

No further illness was noticed for several weeks, when a similar attack occurred which lasted about ten days and at this time general abdominal tenderness and pain were present. During the next three months she became more and more exhausted, lost forty pounds in weight, and in spite of a strict diet has

suffered from frequent attacks of severe abdominal pain, tenesmus and bloody diarrhœa, but nausea and vomiting have been absent.

The present attack began six days ago and since then she has had great nausea and vomiting, frequent stools and very severe paroxysms of pain.

Examination disclosed a very emaciated, anæmic patient with drawn face and sunken eyes. Vomiting was occurring every few minutes and was dark green in color and of a foul but not faecal odor. Tongue was moist and not heavily coated. Temperature was 97.4°, pulse 120 and weak and respirations 22. The abdomen showed marked ascites but no distention, little rigidity, no tenderness except over a mass in the right iliac fossa, the size and outline of which could not be distinctly made out, but which appeared to be firm, more or less irregular in shape and freely movable. Vaginal examination disclosed a flattened cervix with a firm, rounded, slightly movable tumor, about the size of a baby's head at term, lying in the pelvis. With bi-manual palpation the two tumors gave the sensation of being parts of the same growth but separated by a pedicle. Rectal examination was negative except for the tumor in the pelvis and hæmorrhoids. A diagnosis of bowel obstruction, probably due to malignant disease, was made and an exploratory incision decided upon.

The incision was made through the left rectus as the tumor was at this time lying in the mid-line of the abdomen, a large quantity of serous fluid was evacuated and the abdominal tumor was found to be an intussusception and the one in the pelvis a uterine fibroid. The intestinal walls were so nearly gangrenous that very slight pressure caused a perforation with the evacuation of foul faeces. The intussusception was delivered, resected, a lateral anastomosis made and the abdominal wall closed except for a dressed tube drain into the pelvis. The intussusception was entirely enteric, the intussusciens was thirty centimeters in length, but the amount of intestine which was removed has not been determined as it was impossible to reduce the invagination. Dr. Weaver, who prepared the specimen for the museum, stated that it must, on account of it being so tightly packed, have involved a large part of the small intestine.

The convalescence was uninterrupted, except for a severe diarrhœa, the stools being offensive and containing bile and



undigested food. In spite of this the patient gained rapidly in weight, over three pounds during the last week in the hospital, and was discharged on the third of May, 33 days after the operation. Since then her health has steadily improved, most of her strength has been regained and she suffers from no digestive disturbances.

#### DISCUSSION.

DR. H. M. GAY: I wish to mention a point in connection with the etiology of this subject. In the cases that I have seen the ileocecal valve was always drawn into the lumen of the colon. It would seem to me to be very easy for the peristaltic ileum when pouching into the caput coli to be drawn in or swallowed. I do not believe that intussusception can occur here unless there is an abnormal laxity of the mesocolon. Such laxity is undoubtedly one of the predisposing factors.

DR. J. M. HEIMBACH: I have never had a case of intussusception and I should like to ask in what kind of a patient the condition is likely to be found. Are these persons of the emaciated type or are they persons in fairly good health at the time they are taken ill?

DR. H. S. NICHOLSON: I should like to add to this discussion an interesting case that came under my observation. The patient was a child of thirteen months old apparently in perfect health. The child was taken ill suddenly, awakening from sleep with a cry of pain followed by vomiting. A little distention was observed in the upper abdomen and a remedy for indigestion was given. She did not become seriously ill until about twelve hours after and it was thought by her father, who was a physician, that there might be some bowel obstruction. After a period of twenty-four to forty-eight hours, I was called to see the child who was lying with the thigh drawn up against the abdomen and the head buried in a pillow. The child had spasms of pain but did not cry out sharply. On examination the abdomen was found to be distended. Coils of intestine were sticking up and there was a little peristalsis. Palpation disclosed a tumor in the right iliac region which could also be felt through the rectum.

There were movements containing bloody mucous. We tried to reduce the intussusception by forcing water into the bowel with the child held upside down.

Dr. Moreland tried to introduce air through the proctoscope with no result. The abdomen was opened fifty hours after the

onset of the condition. The whole of the large intestine was telescoped into itself, nothing being left out of the intussusception except the appendix. The intussusception was readily reduced by the simple traction, but the cecum and the appendix then remained at the under surface of the liver. The mesentery of the cecum and ascending colon was fully three and a half inches long. It is possible that the congenital position of the cecum and ascending colon had something to do with the occurrence of the intussusception. In foetal life these structures lie entirely to the left, but after birth they rotate to the right and become fixed in the right iliac fossa. This had not occurred in this child and this fact may bear relation to the cause of the intussusception. There was quite a long mesentery in this case. After the operation the child made an uneventful recovery.

DR. J. D. ELLIOTT: The cause of intussusception is a debated question. Laxity and ptosis are undoubtedly the principal causes. In answer to Dr. Heimbach's question, I would say that intussusception may happen in either of the type of persons mentioned by him.

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## INGUINAL HERNIA OPERATIVE TECHNIQUE WITH REFERENCE TO THE ANATOMY OF THE INGUINAL REGION, AND DISPOSAL OF THE SAC.

BY

J. H. THOMPSON, M. D., PITTSBURGH, PA.

THE term "hernia," strictly speaking, may be applied to any protrusion or projection from the surrounding surface. When used alone, the term "hernia" has come to be synonymous with rupture, and is applied to a protrusion of some one or more of the abdominal viscera through a normal or abnormal opening.

While rupture is the term most commonly used by the laity, in describing this condition, it is misleading, since it rests upon a false conception of the etiology. The term originated at a time when it was generally believed that traumatism, or a tearing of the muscular structure by some direct or indirect violence was a frequent and important cause.

The great increase in our knowledge as a result of the large number of operations for the radical cure of "hernia," that have been performed during the last two decades, has proved that in the vast majority of cases, "hernia" is a disease rather

than an accident. In other words, it is due to a congenital defect, i. e., an open funicular process of peritoneum, or an abnormal size of some normal opening in the abdominal wall. This congenital defect, then is the main cause of a "hernia," while the immediate or exciting cause plays but a minor role.

A "hernia" is made up of three parts:

First.—The sac.

Second.—The covering of the sac.

Third.—The contents of the sac.

All "hernias" have been generally divided into two groups, *congenital* and *acquired*. These terms, however, have given rise to a great deal of confusion. Even now there is no well settled rule as to their proper interpretation. Some writers class as *congenital*, all "hernial" sacs which are preformed, and calling *acquired*, all sacs that have developed after birth. This would be an excellent rule were it possible to apply it practically.

Inasmuch as the only way of definitely telling that a sac is preformed, or of pre-natal origin, is by the fact that it communicates with the tunica vaginalis testis, it has been a rule with most writers to class as *congenital* "hernias," only such as showed this connection. This test, however, rules out not only a very large number of cases in the male, in which by reason of the appearance of a "hernia" in earliest infancy, the presence of a preformed sac is practically proved, but it also rules out all cases of "*inguinal hernia*" in the female.

To restrict the term *congenital* to a comparatively small proportion of cases in the male is, I believe, most misleading. It is probable that in the vast majority of "*inguinal hernias*" in the male and practically all in the female, the sac is preformed; i. e., there is an open funicular process of peritoneum existing at birth, even though the "hernia" may not develop until adult life. The principal exceptions to this broad generalization would be the direct "hernias." It may sometimes be possible to distinguish a *congenital* or preformed sac from an actually *acquired hernial* sac, i. e., one after birth, by the intimacy of its relationship to the cord and its vessels in the male and to the round ligaments in the female.

The *acquired* sac, a type of which we have in the direct "hernia," is simply a bulging forward of the parietal peritoneum into some open or weak place in the abdominal wall. This



sac has no intimate connection with the cord or the round ligament.

In a preformed or *congenital* sac, on the other hand, we find especially in children, (and this is equally true whether the sac connects with the tunica vaginalis or not) the sac in the most intimate relationship with the cord and cord vessels, the latter lying in closest contact with the thin membrane of the sac and both surrounded by the infundibuliform fascia.

Some writers have recently gone so far as to class all *inguinal* and *femoral hernia* as *congenital*, with the possible exception of some cases of direct *inguinal hernias*. This position has been taken and most ably defended by R. Hilton Russell. Russell has seen a direct *hernial* sac in the cadaver of a man who had no hernia during life. A number of similar cases of *congenital* pouches of peritoneum have been found in the femoral region in which case, there was no history of hernia during life. Russell cites evidence based upon embryology research, which seems to prove that such pouches of peritoneum actually did occur and not infrequently in the femoral canal. If these facts be true, we have a better explanation of the origin of *femoral hernia* than any that has hitherto been offered.

#### ANATOMIC VARIETIES OF HERNIA.

Among the most common varieties in their order of frequency are as follows:

First.—Inguinal.

Second.—Umbilical.

Third.—Femoral.

Fourth.—Ventricle.

#### CLINICAL VARIETIES OF HERNIA.

First.—Reducible.

Second.—Irreducible.

Third.—Inflamed.

Fourth.—Strangulated.

#### ETIOLOGY OF HERNIA, PREDISPOSING CAUSES OF HERNIA.

In addition to the presence of a funicular sac, or one of prenatal origin, the following may be mentioned among the pre-

disposing causes of hernia: Age, sex, heredity, occupation, obesity, pregnancy, and certain constitutional diseases.

The literature accumulated on this subject of *inguinal hernia*, would almost convince anyone in this branch of surgery that the last word had been spoken.

The anatomy is well known, the pathology has been amply described, and the etiology is generally admitted to be based on the presence of a congenitally preformed sac. The technic has been made more uniform and is guided by certain broad underlying principles. It would seem then that there is no phase on the subject of "hernia" which has not been amply treated by the ablest of writers. Yet this is not strictly the case. I refer to the question of the presence or absence of the conjoined tendon of the internal oblique and transversalis muscles. In the text book on anatomy, the conjoined tendon is described, but not accorded much prominence. Here and there it will be stated that the tendon may be absent. By closely observing the anatomy of this region during the performance of a "hernia" operation, one will soon be convinced of the frequency with which deviations from the normal occur. The tendon is sometimes narrowed and poorly defined, more commonly it is entirely absent. In this case, the fibres of the internal oblique and transversalis pass directly inward, toward the edge of the rectus without forming any tendinous union. The lower portion of the muscles as they pass inward, will be often found much thinner than normal, and there may even be spaces between some muscle bundles exposing the transversalis fascia beneath. If the conjoined tendon is absent, to what extent might this predispose to direct or indirect "hernia"?

At present we are beginning to appreciate the fact that the great predisposing cause in all *inguinal* and practically the majority of *femoral hernias* is a *congenital* or preformed sac. And on the basis of this the first essential principle of a radical cure must be the thorough removal of such a sac.

One is justifiable in operating on both sides in patients who present a fully developed "hernia" on one side, and a weak groin on the other. When this has not been done, patients frequently return years after with a real "hernia" on the other side, proving that the diagnosis "*predisposition*" was well founded.

There can be no doubt that the development of a direct

"hernia" is found in those cases where the conjoined tendon is absent. Our choice of operations should be determined by the anatomic findings. We all have met with cases in which it would have been impossible to perform a typical Basini operation, owing to the absence of the conjoined tendon and the high insertion of the muscles with the rectus, the former could not be brought down to Poupart's ligament without creating too much tension. The technique which is best adapted to meet the requirements of these cures is the imbrication operation of Andrews. By bringing down to Poupart's ligament the edges of the fascia of the external oblique, and as much of the muscle as possible, a very firm covering for this weak area is secured, which is further fortified by the overlapping of the lower flap of fascia. In cases where the triangle is especially large or the external oblique aponeurosis is particularly thin, the Bloodgood technique will be found of service. By incising the edge of the rectus sheath, the muscle fibres are exposed and a portion of the muscle can be brought down and sutured to Poupart's ligament, thus supplanting the conjoined tendon which is absent. The operation can be completed after the Andrews method. (William Hessest, M. D.)

Young discusses the various operations for inguinal hernia, but says that none so logically answers the necessities of the condition as the one devised by Lexer, which he describes as follows: The skin and aponeurosis of the external oblique are divided in the usual way, and the sac freed as far up as the internal ring, where it is ligated securely as high up as possible, but not yet removed. A pair of slightly curved forceps is now passed under the free margin of the conjoined tendon, insinuating them gently upward between the muscle and peritoneum for a distance of about two inches. Here the point of the forceps is pushed forward through the muscle. Into the jaws of this forceps is now introduced the jaws of a second pair of similar forceps, locking them securely and withdrawing the first pair, thus conducting the second pair along the route of the first down toward the internal ring. The loose end of the sac is now clasped in the jaws of the forceps which have been thus placed, and the forceps withdrawn. This brings the sac out through the muscular tissue at a point about two inches above the internal ring. It is pulled down until the neck of the sac or point of original ligature comes to lie firmly against the pos-



terior surface of the muscle at this point, a thing which requires no great amount of force. Two or three sutures now anchor the sac to the muscle and the redundant portion of the sac is cut away. The Basini operation may now be performed or any other procedure resorted to which the requirements of the case may seem to indicate. Should the surgeon wish to avoid drawing the sac through the muscular tissue, he may proceed as follows: Having ligated the sac, he leaves the end of his ligatures long and threads each upon a needle. He then removes the sac and passes an additional suture through the neck of the sac, and again threads each end upon a needle. He now inserts a finger under the free margin of the conjoined tendon and dissects it bluntly from the peritoneum for a distance of about two inches, at which point he passes his needles through the muscular tissue from within outward in such a manner that his knots when tied shall lie in a direction parallel with the muscular fibres, and about a centimeter and a half apart. The tying of these knots now draws the neck of the sac firmly up against the posterior surface of the muscle. The author says that when surgeons in general understand more perfectly the object aimed at, and always to be kept in mind in such operations, the old practice of leaving the neck of the sac at the mouth of the hernial opening to invite recurrence will become obsolete.

#### CONCLUSION.

First.—“Hernia” is a disease rather than an accident.

Second.—The conjoined tendon being absent more often than has been generally observed precludes the performance of either the special Basini’s or Ferguson’s operation.

Third.—Andrew’s operation fulfills all indications where conjoined tendon is absent.

Fourth.—The proper disposition of the sac in *inguinal hernia* is of great importance to a successful operation, and the old practice of leaving the neck of the sac at the mouth of the hernial opening to invite recurrence will become obsolete.

**ECTOPIC PREGNANCY: A PLEA FOR EARLY DIAGNOSIS.**

BY

W. S. PIPER, M. D., CLEARFIELD, PA.

It is not my intention to enter into a full description of ectopic pregnancy, but merely to present a general consideration of the points that particularly impress me.

Very few cases of this condition are brought to the attention of the surgeon until actual rupture has occurred, and mostly when the patient is in a serious or critical condition, this is not always due to negligence of the attending physician, as frequently no complaint has been made until rupture occurs, but greater vigilance on the part of physicians in general will greatly reduce the number of cases that progress to a dangerous point.

In my opinion, a physician should impress on every newly married woman the importance of a rigid pelvic examination, and a record taken of every abnormality or possible cause of future trouble. With a complete record taken at that time, differential diagnosis of future troubles will be greatly simplified.

Every case of sharp pain in the lower abdomen should be given careful examination, especially if accompanied with history of irregular menses or other pelvic trouble.

Among the aetiological factors, the most prominent is, lesions due to chronic tubal inflammation, although neoplasms, kinking, adhesions, fetal type of tube and endometritis must be considered. Delaney, of Altoona, in an extensive experience, has been able to elicit a positive history of coitus during menstruation in 38 per cent. of cases, and feels that it is an important point to be considered in taking histories.

Given a patient in any period of the child bearing age, but particularly one who has never borne children, or has passed through a more or less lengthy period of sterility, giving a history of a missed menstruation or any irregularity, with or without symptoms of pregnancy, with sudden sharp pains in lower abdomen, ectopic pregnancy should at once be suspected and careful bimanual examination made. If bluish tinge of vagina, softening of cervix, slight enlargement of uterus and boggy

soft mass in one tube is found, that case should have an immediate abdominal section before rupture has occurred.

It must not be forgotten that normal pregnancy may co-exist with ectopic gestation, and that it may also occur with perfectly normal periods and no symptoms of pregnancy.

In the differential diagnosis, if the trouble is in the right iliac fossa, the most important affections to consider are appendicitis, pus tube, ectopic pregnancy, urethral calculus and ovarian cyst. Any of these may be confusing, especially in early cases.

Appendicitis usually starts with its typical symptoms, vomiting, epigastric pains, tenderness over McBurney's point, constipation and temperature. You may also elicit tenderness over the eleventh and twelfth dorsal spinal nerve, which is absent in ectopic gestation. In pus tubes the tender point is at the first and second lumbar.

Renal calculus is accompanied by urinary symptoms, pain extending into groin or vulva, and absence of anemia and peritoneal reaction, the tenderness is also usually localized to a definite spot with no distention of abdomen.

On the left side, ectopic must be differentiated from pus tube, ovarian cysts and sigmoid trouble.

When rupture has occurred it is usually accompanied by history of indefinite ovarian or tubal trouble (80 per cent. of cases give history of having suffered with pain in region of ovary for years). There is sharp, sudden pain, collapse, rapid, weak pulse, acute anemia, sighing, respiration, feeling of fullness and urging in the rectum. (This I have come to consider an important symptom.) There is also a drawn, anxious expression and subnormal temperature.

Examination shows dome-shaped abdomen with dullness in flanks. Vaginal examination reveals bulging and boggiess in cul-de-sac. Very frequently there is a menstrual show and a complete decidua may be passed.

If diagnosis of ruptured ectopic is made, the patient should be given an immediate hypodermic of morphine, which helps to control the hemorrhage and has a wonderful effect in slowing the pulse and improving its volume. Abdominal section should be performed at earliest possible moment, it is not safe to wait, as death may occur in a few hours.

Normal saline should be given intravenously or subcutaneously coincident with starting the operation. Clamp and tie the vessels, remove tube and sac. If the sac is in the broad liga-



ment, ligate the uterine and ovarian vessels, enucleate sac and close the cavity in the broad ligament with buried catgut. Carefully remove as much free blood as possible and leave a good quantity of normal saline in the abdominal cavity unless it is necessary to put in drainage. If drainage is indicated, I prefer good sized rubber tube by vagina, in case of much blood, may use both vaginal and abdominal drainage. A pint or more of normal saline, glucose solution or plain water passed into the colon while patient is still under the anaesthetic is well retained and helps to obtain good reaction.

Following operation, large quantities of normal saline, glucose solution or plain water should be used by enteroclysis; personally I prefer plain water, especially if there is any tendency toward albumenuria.

If early diagnosis is made and immediate operation performed, the mortality will be practically nil, but following rupture, and especially those cases that have had several ruptures with organized blood clots and inflammatory reaction, the mortality is very high.

To illustrate the above points, I will briefly cite three cases:

CASE No. 1.—Mrs. T.; age 28 years, married four years, no children, suggestive history of gonorrhea several years before marriage. Menstruation regular. Consultation on account of sudden sharp pains in left side which came frequently but were of short duration. Examination revealed early physical signs of pregnancy, with soft, boggy, tender mass in left tube. Operation disclosed unruptured ampullar pregnancy, mass removed, uneventful recovery.

CASE No. 2.—Mrs. M.; age 40, youngest child 16 years. Suffered with pain in right side for many years. No period for six weeks; while lifting bucket had extreme pain and fell on floor in faint, later managed to crawl up stairs. I saw patient one hour after onset of symptoms; patient pasty white, sighing respiration, could only speak one word between gasps, pulse very weak and rapid. I operated one hour later; abdomen prepared with iodine and alcohol. Found ruptured isthmic pregnancy and large quantity of free blood and still bleeding profusely. Saline infusion during operation, continuous plain water enteroclysis following operation. Uninterrupted and rapid recovery.

CASE No. 3.—Mrs. C.; age about 43 years, mother of four children, youngest three years. Had some form of septic in-

fection at last birth followed by persistent pain in left side. Missed one period, at seven and one half weeks after last regular period was taken with severe pain in left side, almost fainted; this was followed by slight menstrual flow, was up in room next day but had constant pain, very tender in lower abdomen and thought she was going to have an abortion; five days later was taken with more severe pain and slight increase in menstrual flow with expulsion of thick membrane; four days later had extreme pain and violent collapse, and I was called for the first time. Patient presented all the symptoms and physical signs of ruptured ectopic gestation, also marked hematogenous jaundice. Operation disclosed ampullar pregnancy of about three months, judging from the size of fetus. Abdomen was full of organized blood and marked inflammatory reaction. Death two days after operation.

The only cases that I have been connected with that have died were cases of late operation. Operation before rupture has occurred is practically without danger, when rupture has actually occurred, it is my opinion that operation should be performed at once and get control of the hemorrhage. I consider it a dangerous practice to wait for hemorrhage to stop spontaneously, and for patient's condition to improve, as many cases will be lost in that way. The patient's condition will improve on the table if saline infusion is being given during the operation. If patient's condition is critical after operation, transfusion would be indicated.

#### DISCUSSION.

DR. H. M. GAY: The subject of ectopic gestation is one that should be of especial interest to every physician. A few years ago I presented a paper on this subject before the State Society, in which I called attention to the fact that the history of the case is the important part of the diagnosis. We read in the text-books that it may be confused with tubo-ovarian inflammation with normal pregnancy and with new growths. My own observation has been that ninety-nine cases out of a hundred are not confused with any of these things, but are diagnosed as dysmenorrhoea. When we consider how rapidly the fallopian tube is distended by the growing ovum, you can realize why this is the case. Usually about the fifth or sixth week the patient begins to have pain and a reddish discharge from the uterus and believes that the pains are due to some disturbance in menstruation. She consults the family doctor for

something to relieve the menstrual colic and he prescribes with this in view. A few days later the condition becomes markedly aggravated. If you are consulted by a patient who complains of delayed menstruation, a slight tumor in the right or left inguinal region with peculiar pains and fainting spells, you are justified in advising laparotomy.

ANNA C. CLARK: A patient of mine was spending the summer in the country and a physician who was called in said that she had sciatica so severely as to cause constant nausea. The condition did not yield to treatment and the patient began to have fainting spells with attacks of pain. She was very anemic and when I examined her I found a large mass around the left tube. The patient grew rapidly worse and on the following morning the abdomen was opened. We found it to be full of blood and an ectopic gestation of about six weeks. The patient made a complete recovery. There was no bloody discharge. The excruciating pain down the sciatic nerve apparently accompanied the rupture of the tube.

DR. E. P. CLARK: But I would like to emphasize the fact that extra uterine pregnancy produces exquisite tenderness in the abdomen.

DR. G. A. VAN LENNEP: I want to emphasize what Dr. Piper says in regard to the importance of immediate operation when an ectopic gestation has produced a rupture of the tube: the hemorrhage should be stopped at once and you can combat the shock on the operating table as well as you can while waiting for the hemorrhage to cease of its own accord.

DR. G. P. STUBBS: I would like to call your attention to an unusual case that occurred in my practice a few years ago. I operated on a patient for purulent salpingitis of the right tube; the left tube was apparently normal. In four or five weeks the patient began to have pains on the left side and an exploratory incision was made and the left tube was found to be distended with a five weeks' ovum. There was no reason to suspect ectopic pregnancy at the time of the first operation; yet the history of the case shows that such must have been the case.

DR. G. W. HARTMAN: The patient seen by me in consultation showed a large mass on the right side, but the incision disclosed a foetus of five months' development. The history of the case showed that the rupture had occurred three months previously on a railroad train. The chorionic tissue was attached to the abdominal organs and the gall bladder and thus obtained the nourishment necessary for the development of the foetus until the time of operation.



## Bureau of Materia Medica and Provings

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### REFLECTIONS OF AN ABSENT-MINDED THERAPIST.

BY

OLIVER SLOAN HAINES, M. D., PHILADELPHIA.

SOME years since a famous specialist in nervous disorders called my attention to the fact that I was an absent-minded therapist. The occasion upon which this accurate diagnosis was made, happened to be my failure to recognize syphilis as the underlying factor in an obscure brain lesion which I had been treating along homœopathic lines without success. Thereupon we gave potassium iodide, which helped more than my remedies; yet did not cure. I subsequently learned that the specialist was also suffering from my own ailment because at the autopsy of my patient we saw at once that he had not needed medicine, but an early operation. A surgeon told me after the autopsy that the growth was one that might easily have been removed and that my patient could have been saved.

By carefully watching, when I have had the chance, I have formed the conclusion that this malady—absent-mindedness, is widespread among the members of the medical profession, and that it is not uncommon for them to overlook the really paramount features of the case, not uncommon for them to fail to perceive those fundamental elements of a case which control their understanding of it and their ability to treat it successfully.

Quite recently a member of the high dilution wing of our school informed me that the graduates of my alma mater all suffered from this malady, in fact, were born with it. But, as my high dilution friend is himself almost dead professionally from what appears to be the same thing, we may conclude that it spares no class, neither high nor low dilutionist, neither practitioner nor specialist.

But, gentlemen, it is hurting homœopathy, and that is the reason we should consider it most seriously in its relation to this special department of therapeutic art. I know that this society stands ever ready to fight anything that retards the progress of homœopathy.

For the benefit of those of you who just now for the first

time realize that you yourselves may be the victims of this disease, let us remember that it may be just as easily acquired by intense concentration upon one subject as by simple inattention with its characteristic aimless wanderings of thought. My high dilution friend contracted his through intense concentration upon one subject; and, was miles behind the times before he realized it.

It seems so natural for the human mind, unless coerced, to think on any subject presented to it; either in an aimless, inattentive way; or, else to concentrate all its power upon one single phase of the subject. The mind that is not compelled rarely does much systematic work. Therefore it is only by special effort that one gets breadth of view; and, at the same time, a correct appreciation of the special aspects of the subject requiring minute attention.

The weakest spot in all medical practice is lack of adequate investigation. The weakest spot in the practice of our special therapeutic system is our *a priori* presumption that we "know" the remedy our patient requires; and our unwillingness to proceed with the analysis of the case to that final sifting of remedial measures—to the point where we can clearly and unmistakably perceive that there is a similitum that exactly suits the necessities of the case.

The absent-minded man presumes instead of finding out; and nothing makes for failure in the practice of our therapeutic art like *a priori* assumptions which do not rest on the broad and substantial basis of facts and experience.

If one will put his *a priori* presumptions to the ordinary test of repertorial analysis, he will be astonished; and the result is sure to be his conviction that it is very difficult to select one remedy that will cover every phase of a morbid picture. Yet that is what homœopathy demands of her practitioners.

And while we cannot say that the absolute accuracy of our prescription is always the sole determinative factor in our successes; still it is the thing that we can control. And after the perpetuity of homœopathy has been discussed from every angle, you will have to admit that it will be our *results* that will count. Favorable results and a judicious publicity for the same will help along our special therapeutic system as much as anything else you may mention.

The phenomenal growth of our school in its earlier days was due to no other factor so much as to the grateful praises of

the thousands of people who, having failed to obtain relief elsewhere found it in the simillimum, and having found it told others. Our rapid rise to a great school of therapeutic specialists was not due to our colleges, nor to our literature, nor yet to our political influence in the land; it was due to the *results* obtained. Now our growth should be much more rapid to-day than it was in the past; because we do much better work in a general way than we could have done fifty years ago. We ought to be doing much better work in our own special way, but I sometimes fear that we are not.

It is my firm conviction that what is most needed to-day by our school is greater accuracy in the prescription. We do everything else to-day quite as well as any other class of medical men.

If you wish to be convinced, ask every new patient what caused him or her to consult you professionally, and note how often they reply, "Because I have not been satisfied with results obtained by my former physician." It is just the same to-day as it was in the beginnings of our school, only we have forgotten the factors that have made us great, and it does seem that a clearer recognition of the potentiality of the single remedy homœopathically applied, and greater accuracy in the prescription would help a lot just now.

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### POTENCY: AND WHERE IT IS FOUND.

BY

ROBERT WALTER, M. D., WALTERS PARK, PA.

THE source of power in general, if not in particular, is a subject of never-ending significance. We observe its effects, but the power itself forever escapes observation. Out from an invisible realm has come forth universal existence, magnificent in extent as well as infinite in numbers and varieties, all of which are manifestations of power such as the human mind may, indeed, contemplate but can never fully comprehend. This much we have learned; the power that made the worlds is in the worlds to preserve what it made and to carry forward all their operations.

This is, indeed, a truth of observation, but science rests its



claims not wholly upon observation. The scientist is called upon to view Nature as she is, and not as she appears to be; for it is proverbial that appearances are deceptive and observations, therefore, unreliable; truths written into the constitution of things prove that we dare not trust even what we see. But reason clearly asserts that the power that produced the worlds, and every part of them, is not only in them, but must have been before them. Power before product is a necessary conclusion of the human intellect, so that power, known in science as force, is of necessity original, the *cause* and *source* of all that is.

But the worlds exist in varied stages of development, first of which is *matter*, and after that is *mind*. Before the matter as we are familiar with it, are elements and atoms, and there must have been a power which has converted these into compounds. This power has generally received the name affinity—chemical affinity—a force resident in all matter to preserve its constitution under one set of conditions, or to change it in response to another set, so that conditions, which are forever varying, make changes to be forever occurring. There is nothing at rest; universal motion involves universal change. It has been observed that out of a few elements over one hundred thousand distinct and separate compounds have been produced, which compounds are ever changing in response to ever-changing conditions. The power is always the same, illustrative of the character of its Author. It is the same force that both produces and destroys, combines and disintegrates, daily performing an endless variety of operations, the force of production ever continuing in the product to preserve what it has produced, or change it as occasion demands. It makes dynamite and gunpowder and explodes them, and constitutes the force of the explosion; makes acid and alkali, bitter and sweet, and continues with an infinite variety of activities in response to what occasions arise or conditions exist.

These compounds exist in masses as well as in elements, and as such are subject to another force best known as gravity or gravitation. This also is both universal and unchangeable, dealing with and controlling the relation of masses to masses throughout the universe. Like affinity it is a responsive force, responding with ever varying certainty to every change of condition and circumstance. It made the spheres, preserves them as spheres, revolves them in space as well as around their own

centres of gravity, so constituting the firmament, and producing all the phenomena of the physical heavens. It brings down the rains to water earth, forming rivulet, river, lake and sea, and Mr. Spencer to the contrary notwithstanding, carries up the mists to form anew the rains. It floats the kite and balloon or dashes them to earth; sails the ship or sinks it; enables us to swim or drowns us; makes both storm and calm, bringing water to its level or raising the waves mountain high, the most of which results being in response to the degree of heat which is generated chiefly in its own operations. Gravity is the *power* and heat is the *condition or occasion* of wondrous phenomena in this world, and only ignorance or prejudice confounds them.

But the worlds were formed to be inhabited; living existence is as certainly a part of the original creation as that rain and sunshine, mountain and valley, ocean and lake, are its products. Are we indeed supposed to inhabit a purposeless universe? Did the universe create itself, and if not, how shall it create its own producing forces? Can something come out of nothing; and if not, how shall the thing which comes exceed the Source whence it comes? Can the stream rise higher than its source, the small include the greater, wisdom be the product of folly, mind spring forth from things without mind, life out of no life? No fact of Nature stands forth in clearer outline than that life comes only from life. While it is everlastingly true that no science can rest solely on observation, it nevertheless is true that science has never denied, and never dare deny the facts of observation except to its own destruction. All the sophistries of all the ages have proved insufficient to blot out the ever-present fact that you and I are the fruits of ancestry—of forces of thought and will and impulse similar to that which we ourselves possess. Vitality, the power of life, is as truly inherent in living things, without which they could not have come into being nor continue to exist, as that gravity and affinity were before and are inherent in material things: what reason, therefore, to doubt that the source is the same in either case. The Great Apostle has well said, "He giveth to all life and breath and all things," a truth quite as certain as that he has endowed matter with gravity and affinity. The facts cannot be disputed. Nature exists, as long ago established, in three fundamental departments, chemical, mechanical and vital, each the product of its own fundamental force, proved by the fact that no other force has proved sufficient to its

production, and being fundamental, it is of necessity before its product. Life was before living things just as certainly as affinity was before compounds or gravity before spheres. These are Nature's producing forces that cannot be produced—non-producible, and as we have reason to believe, non-destructible as well. Death is not the destruction of life any more than the exploding of gunpowder is destruction of its elements or its forces. Nature is a trinity, composing the unity or universe of which man and mind are its crowning achievements.

But there is another class of forces in Nature, the opposite in all essential respects of the producing forces mentioned. The members of the first class are inherent in the things in which we find them while those of the second are incidental to them. The one set are intrinsic and the others extrinsic; the one are producers that cannot be produced while the others are their products; and finally, it is clearly evident, that the one class are the *causes* of all results while the other class are *occasions*. Both are universal in Nature, and both have to do with production. For it is obvious that at least two things are necessary to any and every result:

*First, the power that produces, and*

*Second, conditions or occasions for the operation of the power.*

These two things are embodied in the two classes of forces mentioned, affinity, gravity and vitality being the *causes*, and therefore supplying the *power* of all results, while heat, light, electricity and magnetism are occasions which bring into operation the power. For illustration: Steam, the product of combustion, a chemical process, is the power that propels the locomotive, but how propel it without conditions by way of boiler, engine and wheels? Water is the product of the same chemical force, operating upon two gases, oxygen and hydrogen, but though these gases be thoroughly mixed no water is produced. If now we introduce a spark into the mixture a tremendous commotion occurs, and water is the product. Who will say that the power that made the water was in the spark; on the contrary, we all know it was the affinities in the gases that combined them into water, the spark being simply the occasion that induced the operation. In our practice as a physician a simple dose of aconite seemed to cure a case of inveterate insomnia, in which chloral and bromide had utterly failed, and along with this insomnia, cured a heart disease, diagnosed by



an eminent specialist as *aortic stenosis*; but who believes that the aconite supplied the power of the cure? The power was without doubt in the patient, aconite supplying the condition, or furnishing the occasion, for its operation. An infinitesimal spark also will explode dynamite or gunpowder or set up a conflagration that will destroy a town or forest, but no one believes that the spark supplies the power of the explosion or conflagration. On the contrary, it cannot be disputed that the power resides in the compound, the spark being simply the *occasion* that brings into operation the *cause*. A cause is properly defined as, "That by the power of which an event or thing is," while an occasion is an incidental occurrence which brings it into operation. It is the power of life in the patient that repairs, heals, cures—does all that is done, medicines or other treatments but directing its operations, just as it is the power in the gases that makes the water or in the dynamite that explodes it.

The relations of the living organism to things extraneous is a question of philosophy which applies to medicines, and food, as well as to all other forms of environment, including air, water, clothing, etc. Are these *causes* of vital functions or are they only *conditions* of vital expression? Do they supply the power that operates, or are they simply occasions for its operation? Perhaps no two words in our language are so frequently confounded as the words *cause* and *occasion*, for the reason that causes are invisible potencies, while occasions being obviously connected with the result are too often mistaken for the cause, an error quite excusable in the illiterate, but that a great philosophy should be built upon it, is inexcusable if not unforgivable. Herbert Spencer has deliberately sought to establish the principle that all results are the product of environment, that is, of influences from without. Admitting the fact of Heredity, which he says he cannot understand, he soberly tells us that chickens are the product of heat, so ignoring both male and female bird: he asserts also that all (his) "ideas and feelings" are derived from physical forces "expended in producing them"; thereby constructively admitting his philosophy to have been built up from London fog: he fails to tell us how things were produced while as yet there was no environment to produce them. He mistakes occasions for causes, ignoring both gravity, affinity and life, because of their intangible nature, and exalts to the position of producers

the things which Nature herself produces, and so seeks to justify the doctrine of a self-created universe. We dispute both his processes and conclusions. *Causes* are invisible but intrinsic potencies, inherent in the constitution of things, while *occasions* are extrinsic but generally obvious and incidental. Chemical affinity, gravitation and vitality are the causes of all operations in their departments, inherent in the things in which we find them, gravity and affinity in all matter, and vitality in all living things, without which they could not have come into being or continue to exist. They are producing forces that cannot be produced; they were before the worlds for by them the worlds were created; they are in the worlds to maintain their existence and perform their evolutions. In and by virtue of these evolutions they have produced heat and light, electricity and magnetism, all of which are "modes of motion," occasions of wondrous operations but causes of none.

The mechanical realm illustrates the same principles as does the chemical. Under one set of conditions the kite, balloon or aeroplane will sail securely through the air, or under changed conditions, may fall to its destruction, gravity being the cause of each operation. Why not the same principles apply in the living world? Vitality, the power of life, having made the living organism, remains in it to preserve what it made, performs all its functions, of which repair is the most important, produces both health and disease, and turns the one into the other, all being responses to conditions or occasions, the control of which is the physician's duty. The power of cure is an inheritance, born into the patient, as insurance men well know, and upon which they calculate risks; it is the physician's work to supply the conditions of health, and frequently also occasions for the operation of the power. Thus, while Nature supplies the power that does all the work, the physician can at best furnish the conditions and occasions for its operation, for which reason an infinitesimal dose will prove quite as effective as a dose ten million times larger. As the smallest spark will explode a ton of dynamite or a barrel of gunpowder just as quickly as will a live coal, so will an infinitesimal dose bring into operation the power of cure, which is already in the patient, and will do so without wasting or exhausting it. Medicines are important occasions of vital action; they are the switch that determines the direction of the movement, while they no more supply the power of the movement than the railway or electric

switch, supplies the power which they direct. Unless the power is in the patient no medicines will ever effect a cure, the similar medicine proves effective only because it directs the power to the disease and not away from it. Disease is a manifestation of life in response to unfavorable conditions, which it is ever seeking to remedy, and should be aided as does the similar medicine and not thwarted, as the contrary medicine is intended to do. The one promotes recovery and the other prevents it; the one operates with and aids Nature while the other opposes and exhausts her; the one makes permanent cures while the other makes more or less permanent invalids. Definitions are in order:

Health is the normal, easy and comfortable performance of the functions of life, due to favorable conditions and sufficient power, while

Disease is the abnormal, difficult and even painful performance of the same functions consequent upon obstructions from unfavorable conditions and generally insufficient power.

The force of health and force of disease are identical in essence, differing only in degree. The cure must come through change of conditions in such a way as to recuperate, which means accumulate, the power of cure, which power may often be so accumulated as to overcome all obstructions, even in the worst cases, and restore health in spite of unfavorable conditions. Treatments which recuperate power in the patient gain effectiveness by long continuance instead of lose it by repeated applications, as is the rule under stimulating methods, a truth which we have proved in practice hundreds of times.

The first step in the treatment of any case of disease is, to cease the introduction of obstructing materials; the second being, removal of those already existing. The former is a voluntary operation originating in the realm of ideas while the latter is an involuntary process to which Nature is inherently and continuously devoted. To cease the introduction of obstructions we must first learn their source, while removal of existing ones involves the power and process of nutrition as well as of purification. The avenues of ingress to the vital organism are in general terms through the stomach and lungs while those of egress are chiefly through kidneys and bowels, between which, that is, between ingress and egress, occurs a variety of operations wondrously complex and numerous, any one of which may become inefficient and obstructive to the pro-



duction of a variety of difficult and consequently diseased operations. The work of every organism consists chiefly in the disposal of the food eaten, the efficiency or non-efficiency of which work constitutes the essential element of every disease, air and water being aids to the work but seldom increasing it. Water, constituting four fifths of the organism, undergoes no essential change in its course through it; the air also though it yields to the blood an essential constituent, continues still to be the same oxygen: it is the food eaten that must undergo great changes and has within it the elements of obstruction as well as materials of construction. But make no mistake: while food supplies the materials of structure it possesses no power to build. The skill which underlies human development is as much superior to food and drink, as architectural skill surpasses in value the brick and mortar, iron and cement found in the noblest structures. Food, therefore, is not only not nutrition but when used in excess obstructs nutrition. The changes through which it must go in the process of being built into structure, is necessarily effected through organs having limited capacities, which being exceeded, obstructs the processes of life, yielding to us a great variety of diseases of stomach and bowels, liver and lungs, heart and kidneys, and it is failure of one or more of these to accomplish their work that underlies most diseases. These are the workers that expend instead of produce the power of life, while the appropriation of food is the work to be done. The more food the more work; the less food the less work. Over-eating, we believe, makes more diseases and destroys more lives than bleeding and purging ever did, due chiefly to the prevailing belief that in some mysterious way, which cannot be explained, things without life communicate to us the power of life. They do nothing of the kind. On the contrary, food receives vitality from the organism, not gives it. It goes into the organism as dead material but soon becomes living blood, and we properly inquire, Whence the life but from the living organism? True, it yields to the organism physical force for the doing of physical work, but it yields no power of healing or repairing. As well expect steam generated by combustion to repair engine or boiler as force generated from food to repair the organism. If one works he must eat, but as he ceases physical work he should cease, or at least reduce, eating. Rest *within* is quite as important as rest *without*; fasting and not feasting—the bed and not the workshop, is the

place for the sick. The power that made the organism is the only power that can heal it, and this power should be directed to the healing process, which is disease, by the "similar medicine" and not be diverted from it by unnecessary food or by the contrary medicine. Food, like air, water, clothing, etc., is a necessary condition of living existence on the earth, but under **no circumstances supplies the power of life.**

The process of nutrition, involving the appropriation of food, takes place in and by virtue of circulation in the minute capillary blood vessels which connect the arterial with the venous systems. In other words, the highly vitalized arterial blood must pass through vessels minute enough to reach every cell, where it becomes a dark blue, venous blood, because it has left with the cell its vitality and absorbed from it its devitalized materials. If now for any reason the nutritive materials in the arterial blood exceed the ability of the cell to receive and appropriate, there must follow, of necessity, delay, and increased labor of the organs of circulation, provoking to congestions, heart failures, etc.

But if the arterial blood must become venous in its passage through the general capillary system how much more certainly must its arterial character be restored by its passage through the capillaries of lungs, liver, bowels, kidneys, etc. None of these organs possess unlimited capacities, liver and kidneys being very generally overburdened with work while torpid bowels is a usual condition. Is it any wonder therefore, in view of prevailing belief that food is the source of the power of life, that the burdens of circulation should in our day be greatly increased and nutrition obstructed, to be followed by the ever-increasing neurasthenias, melancholias, suicides and insanity, and especially heart failures that follow. If, therefore, instead of removing the obstructions, as was formerly done, by bleeding and purging, the profession persists in adding to them by forced feeding, in spite of Nature's protests as shown by loss of appetite, if not repugnance to food, and in addition proceeds to exhaust the power of the organism by the use of tonics and stimulants, whether in the form of drugs or cold baths, all of which by arousing vital resistance, give an appearance of power, which cannot be intelligently conceived other than as power drawn from the patient instead of communicated to him, what can we expect but prevailing diseases? Such treatment is

a system of depletion just as certainly as bleeding and purging ever were, but in this case it is depletion of power refined to the highest degree as nerve and brain force instead of the foul blood which bleeding and purging removed.

It cannot be doubted that bleeding relieved the purifying organs of much labor and gave ease and comfort correspondingly, but who will show us compensation for work increased through tonics and stimulants? These enable us to do more work, and so add to the burdens already existing, but what is needed in order to cure diseases is less work and more power, not more work and less power. Removing venous blood laden with impurities reduces the work and saves the power, while stimulants and tonics, whether as poisons or other imposed violence, increase the work and deplete the power. We propose a better plan than either, viz., to cease the use of the materials of which blood is made and so avoid the labor of making and circulating it. It were absurd to impose upon stomach, liver and lungs the work of making blood, and upon the heart the work of circulating it, only to open a vein and throw it away. Blood is valuable, it has cost much labor to produce it and should be saved not wasted; the labor of producing it however may often be avoided to advantage.

And thus we reach the all-inclusive step in the restoration of health and consequent cure of disease, viz., the accumulation of the power of life, which is the power of cure. This power, we have seen, is an inheritance and not a product, as the insurance companies have long since decided. They never ask how much a man eats but they do want to know about his parentage.

But while vitality cannot be manufactured it can nevertheless be hoarded. We expend it in the labors, excitement and activities of the day, all of which give an appearance of strength, while we save and hoard it during the helplessness of sleep. Experience thus proves that we get strong by being weak as we get weak by being strong, the secondary and real effect of all habits being the opposite of those which are apparent and temporary.

And now in conclusion we would condense into a few words this whole subject:

First, the power that made the organism is the only power that can heal or repair it, all appliances from without, whether



food, drink or medicine, being but conditions or occasions for its operation.

Second, this power is an inheritance from previous life, and not a product, any more than is gravity or affinity, all of which are creative forces. Vitality made us but cannot be made by us, any appearances to the contrary being delusive.

Third, the rapidity and certainty of cure correspond with the amount of vitality, which is being hourly expended in the activities of life and recuperated by rest and sleep, the difference between these determining the amount of available power in possession of the invalid.

Sleep, and all such treatments as operate as sleep does, by reducing activity and relaxing tension, recuperate power and promote recovery, at the time and by the very means, that they produce apparent but temporary weakness. Thus, relaxing treatments recuperate power while tonics and stimulants expend it, the permanent and real effects being the opposite of the temporary and apparent ones. Medicines being occasions of vital action should direct the curative operations to the disease and not away from it, thus aiding instead of preventing curative processes. Operating as occasions of vital action though supplying no power of cure, the infinitesimal dose proves much more effective than the larger dose ever did or can, and wastes no power in resisting violence as do all treatments based upon the theory that they supply the power of cure when in reality they only direct it, too generally away from the disease, which is a curative process, so preventing instead of promoting recovery.

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PITUITRIN AS A POST-OPERATIVE TONIC.—Used as a post-operative tonic Jaschke observed a stimulation of the bladder function. In half the cases observed the urine and flatus were spontaneously voided on the day of operation. But upon the general condition the pituitrin acted most favorably. Besides slowing and strengthening of the pulse, the blood pressure was increased. From contraction of the splanchnic vessels the distribution of blood again becomes normal, and if the loss of blood is replaced by normal salt solution the action of the pituitrin is sufficient to hold the blood-pressure at a normal figure and to counteract a paralysis of the circulation. The replacement of loss of blood by normal salt solution is urgently to be recommended after every operation and is a prerequisite for increasing the blood pressure by means of this remedy—*Abstr. Zentralbl. f. Gyn.* 1913—42.

**LEST WE FORGET.**

BY

I. D. METZGAR, M. D., TYRONE, PA.

THE tendency among specialists in eye, ear, nose and throat troubles is to look to topical applications for beneficial results rather than to internal medication. So accustomed are many patients to rely upon local treatment for relief that they pursue the application of some suggested remedy to the limit of tolerance and to the accomplishment of positive injury to the affected parts, thus jeopardizing the ultimate possibility of cure. In acute affections of the mucous membrane our internal remedies are most reliable in restoring disturbed circulatory equilibrium and thus aborting a localized inflammation. Likewise, in the more chronic affections, carefully selected medicines, faithfully followed, will exhibit surprising results.

More constantly than we suspect, methinks, are abnormalities in children due to some dyscrasia inherited through some ancestral indiscretion. The child perhaps needs the very remedies, in a modified form, which his forefather willingly or unwittingly ignored. During the nascent period of life much may be done with our constitutional remedies if we are but keen enough to discern the condition and the remedy suitable to it. The calcareas, sulphur, arsenicum, phosphorus, chamomilla, etc., have almost miraculous effects in children needing these remedies in the course of their physical and mental development. Critical care and skillful medicinal aid during the period of growth will obviate the need of much care in adult life. The direful legacy of the ancestor combined with the delinquency of the paediatrist furnishes not a small part of the cares of the eye, ear, nose and throat specialist.

Moreover, aside from these inherited and neglected dyscrasias of childhood, there are presented in this specialty many other conditions amenable to constitutional treatment. Any organ of the body may be made to bear the brunt of some perverted function when the primary cause is general. Suffice it to say, the patient's general condition needs care first while the special localized disease needs treatment secondarily. In view of this fact, it is evident that most any remedy may be indicated in the various conditions presented. The following ten are

a few that have shown positive effects in my own experience:

*Aconite*.—In this remedy we have a picture of a human electrical storm. A serene life is suddenly transformed into an anxious, impatient and fearful state. Startled by the suddenness of the attack, fearful lest some old ailment return, dread of the future,—intense mental disturbance—these intensify the pain and numbness until she is sure some terrible calamity is impending. And so there might be, did not this remedy neutralize the electric tension and quiet the storm.

*Belladonna*.—This is the great head remedy. The blood all seems to rush to the head. Eyes are red and blood-shot, face is flushed, arteries throb, head aches and even delirium may supervene. Such a sudden erythism will mean serious localization unless flagged by this polychrest. Even after the acute fervor has passed, and a red, painful, throbbing inflammation results, belladonna soothes and dissipates the trouble.

*Gelsemium*.—In this remedy, a different picture presents. The patient is all undone,—“a physical wreck,” he says. He doesn’t know whether he is lazy or tired; at best, he can’t make things go, not even himself. He lacks nerve force. Muscles fail to respond to his will, and this consciousness reacts, making him dull, drowsy and morose. Eyelids drop and tremble; tongue is thick and unsteady; vision at times is blurred; pupils dilated, diplopia, simulating intoxication (glaucoma). Pulse is slow and weak when quiet, but easily quickened when startled. Such a semi-paretic state is direful. Gelsemium thwarts the impending danger to the mind and special senses.

*Cicuta Virosa*.—A profound nerve remedy which acts on both the intrinsic and extrinsic eye muscles. Uncertain accommodation and ciliary spasm, asthenopia with alternated contracted and dilated pupils, trembling and twitching of eyelids, —all, shown in a nervous and sensitive person, call for this remedy. There will likely be shown muscular imbalance of uncertain kind and amount. Unsteadiness of body and eyes characterizes this infrequently used remedy.

*Causticum*.—Comes between gelsemium and cicuta. Has the weakness of the potassium salts combined with the unsteadiness of gradually appearing local paralyses. May affect the eyelids, tongue, oropharynx or larynx. In my experience, causticum has been invaluable in these affections and in tinnitus aurium but disappointing in incipient cataract.

*Spigelia*.—Left-sided ciliary neuralgic pain which is sharp,



shooting, stabbing and radiates about the eye. Eye feels so large as to make him dizzy in attempting to turn it in the orbit. Pains come and go with the sun and are worse on motion and wet, cold weather. The patient is apt to be of a sanguine temperament, and is thin, anemic, debilitated with a rheumatic diathesis. Eye strain may predispose to these pains; but *spigelia* serves as a good friend, oftentimes, to the oculist in satisfying the patient that the prescription is correct.

*Sambucus*.—This remedy seems limited in its action but very positive when indicated. "Snuffles" in children, due to dry, stuffy catarrh,—child's skin shows a dry heat when asleep; a smothering spell startles him into wakefulness when he breaks into profuse perspiration. The writer has used this remedy frequently to "tide over" cases of infants afflicted with adenoid growths until such time as operable procedures seemed advisable. Indeed, some parents seem to think an operation unnecessary after its exhibition.

*Mercurius Dulcis*.—Merely mentioned for its effect upon a stuffy condition of the ears. An hypertrophied pharyngitis causes a closure of the oral end of the Eustachian tube and a partial vacuum in the middle ear. *Mercurius dulcis* oftentimes acts as a charm—a veritable catheter—in such conditions.

*Kali Bichromicum*.—Aside from the nasty, stringy discharge from and the tough adherent clinkers attached to the mucous membrane, this remedy has other cardinal symptoms. Acute inflammations which are characterized by intense engorgement, remind one instantly of this remedy. This tense swelling may surround an ulcer, involve the tonsils or turbinates and cause intense pain which shoots toward the ear; it hinders swallowing or causes a heavy pressure over the nose or about the sinuses. Violent swelling of stony hardness with tenacious discharge always makes me think of *kali bichromicum*.

*Hepar Sulph*.—Who could forget this sensitive individual? The mere thought of having lanced a hordeolum or a peri-tonsillar abscess makes her faint. The *hepar* patient is sensitive to cold air, pain, and to touch. This is not only physical but mental also. He is easily irritated, hasty, ferocious or morose. His catarrh, or conjunctivitis, or corneal ulcer, or his boils,—all, "worry him to death." Cure him with *hepar*.

These ten medicines with others with whom I have attained a certain degree of intimate relationship, are gems,—constant, loyal and efficient friends in every time of need.

## A FEW NOTES ON JUSTICIA ADHATODA.

BY

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I HAVE recently been quite interested in studying the action of this comparatively new remedy in the treatment of many of the acute conditions of the upper respiratory tract, and believe it to be a valuable addition to the more common remedies that we all know to be useful in this class of cases. For this reason and for the fact that it is comparatively unknown to most of us, I thought it would be interesting to review briefly what is known of its symptomatology. Further proving of the drug is much needed to verify the work already done and to broaden, if possible, its symptomatology.

My principal knowledge in regard to "Justicia Adhatoda" was obtained from the paper read by Dr. W. A. Yingling before the International Hahnemannian Association in June, 1910. Dr. Yingling quotes Dr. Sarat Chandra Ghose, of Calcutta, who first introduced the drug. The plant, which grows in India, is a small tree or large shrub, flowering in the cold season. The fresh leaves are used in making the homœopathic preparation. Its main characteristic seems to be its action on the mucous membrane of the respiratory tract, and it is said to be highly esteemed in India, its native country, in the treatment of acute colds, coryza, bronchitis and similar conditions. It is purely a remedy for acute cases and after the first stage of the above conditions is practically useless.

The coryza is usually profuse, as is also the lachrymation; there is cough, sneezing (often loss of smell and epistaxis), and more or less noticeable *difficulty in breathing*. You may compare here *allium cepa* and *euphrasia* which are rather similar in action. But we find in *allium cepa* that while the nasal secretion is watery and acrid and the lachrymation mild, in *euphrasia* the reverse is the case, viz., bland nasal secretion and excoriating lachrymation. *Justicia* seems to fit the intermediate cases in that neither the eye nor nasal secretion are markedly irritating.

There is irritation in the throat with cough and more or less difficult breathing, or with the feeling that the cough causes the difficult breathing. This is held to be one of the most marked features of the remedy. The cough is violent and accompanied

by considerable hoarseness. Usually the cough is dry, but if accompanied by any expectoration, this is found to be frothy, white mucus and is only brought up after a hard effort.

There is much difficulty in breathing, the breathing being of an asthmatic character and made decidedly worse by the cough. Both the cough and the dyspnoea are made worse by a change in the temperature, but more markedly so by a change from a cool to a warm atmosphere. The patient can hardly breathe in a close, warm room. There is a feeling of rawness and tightness all through the chest, but, especially, in the sternal region. The throat usually feels dry and it is slightly painful to swallow.

I can do no better than quote from Dr. Yingling's article in giving the main symptoms arising in other parts of the body:

*Mind*.—Anxious and discouraged. Extremely irritable.

*Head*.—Fulness and heaviness, dull headache. ("Headache seems to arise from displaced brain, disappearing on arising, when the brain seems to flop over to normal position.") (Yingling.)

*Eyes*.—Profuse lachrymation with coryza.

*Nose*.—Profuse coryza with constant sneezing. Obstruction of nose. Loss of smell and taste. Epistaxis.

*Face*.—Feels burning and red. Puffiness of face.

*Mouth*.—Mouth, throat and tongue dry and sore.

*Stomach*.—Nausea and vomiting from coughing.

*Extremities*.—Hands and feet puffy and swollen. Tingling in feet.

*Fever*.—Moderate temperature, feeling of chilliness, especially in evening. Pulse moderately increased and hard.

*Dosage*.—3x to 30x.

In summarizing, I would like to call attention to a few important points in regard to *justicia*:

1. It is mainly useful in affections of respiratory tract.
2. Is of little use in cases of over 48 hours' duration.
3. The prominent symptoms of coryza and lachrymation in this remedy are intermediate to those found in *allium cepa* and *euphrasia*.

I wish to acknowledge my indebtedness for the help I have received in preparing this paper from Dr. W. A. Yingling's article and case records of Drs. Wm. Cowley and W. B. Boggess.



## EDITORIAL

### MEDICAL MEN AND THE INCOME TAX.

THE law imposing an income tax upon all persons whose income exceeds three thousand dollars per year in the case of unmarried and four thousand dollars per year in the case of married persons, was passed at a recent session of Congress, and within the next few months all persons will be compelled to make a report to the Government as to their income under the provisions of this law.

A number of important questions have arisen in regard to the application of the law in the case of physicians. The first and most important question that arises is, "What is a physician's income?" Many physicians in the past have been inclined to regard their gross receipts for the year as their income. We have from time to time in these pages pointed out the inaccuracy of such a supposition. The question, however, in the past, has attracted but little interest on the part of physicians; but now that physicians are called upon to pay a tax upon their yearly income, it is probable that this matter will be more carefully figured out.

To anyone who will give the matter a moment's thought it will be evident that the gross receipts of a physician no more represents his available income than the total receipts of a grocer represents his earnings. For a physician to arrive at his actual income, that is the amount available for the personal uses of himself and of his family, it is necessary to deduct from the gross receipts all expenses incidental to conducting his professional work. Among necessary and legitimate expenses of this character are, the rent of his office, the cost of telephone service, the salary of a stenographer or assistant, the cost of instruments, books, medical journals, drugs, surgical dressings and appliances, the maintenance of automobiles, horses, carriages, car fare spent in professional visits, and, in fact, any expenditure necessary to the carrying out of his professional work.

We are inclined to suspect that, after all, these deductions

are made, both tax collectors and the members of the medical profession will be astonished to learn what a poor class of people physicians really are. For example, one physician of our acquaintance who is collecting nine thousand dollars a year was surprised to learn that his professional expenses, entirely independent of any money spent upon himself or family, amounted to \$5,182 a year, giving him a net income available for personal use of \$3,818. A man with a comparatively small practice will, of course, not be affected by the law. Very careful estimates show that the net income available for personal use in the case of the physician whose collections amount to two thousand dollars a year, is little more than eight hundred dollars. We are thoroughly convinced that after the members of the profession become accustomed to keeping accurate accounts of gross receipts and net income, it will be found that *the average doctor has to earn two dollars in order to have one for his personal expenses.* It is probable also that many physicians collecting, say four thousand dollars a year in a rural community, will be found to have a greater net income at the end of the year than physicians practising in large cities who are collecting double that amount.

It is very probable that one effect of the enforcement of this law will be to cultivate more accurate systems of bookkeeping among physicians and to enforce upon them the necessity of greater economy in their business methods. It will also give excellent opportunity to ascertain how the incomes of physicians compare with those of other professional and business men.

G. H. W.

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#### THE PASSING OF A GREAT PHYSICIAN.

ON Friday morning, November 14th, the medical profession lost one of its noblest representatives and the homœopathic school one of its ablest adherents in the death of Dr. James H. McClelland, of Pittsburgh. For many months Dr. McClelland had been in poor health, but such was his indomitable courage and determination to be up and doing that but few realized his end was so near at hand.

Dr. McClelland's activities in the homœopathic profession have been so broad and so varied that scarcely a move of im-

portance has been made in our School during the past forty-five years with which he has not been intimately and actively associated. As an organizer and leader of men, Dr. McClelland had few superiors, and recognition of this fact made him a leader both in local, national and international affairs.

Dr. McClelland was born in Pittsburgh, May 20th, 1845, and was the son of J. H. McClelland, Senior. In 1864 he matriculated at the Homœopathic Medical College of Pennsylvania, from which he graduated in 1867. In that year he began the practice of medicine in Pittsburgh, and his skill and reputation in surgical work was such that, in 1876, he was called to the chair of surgery in the Hahnemann Medical College of Philadelphia. In 1878, Dr. McClelland resigned his professorship in the Hahnemann Medical College and continued the practice of his profession in Pittsburgh. The universal esteem with which Dr. McClelland was regarded in that community, together with his skill as a physician and surgeon, rendered him a great power for homœopathy in that city and the two magnificent homœopathic hospitals of Pittsburgh owe their existence largely to his activities and public spiritedness. Not only was he chief of the surgical staff up to the time of his death, but for fifteen years he served as Secretary to the Executive Committee and Chairman of the Medical Board. His membership in the American Institute of Homœopathy dates from 1867, and from that time until the day of his death, the interests of the organization were constantly at his heart. Even during the last weeks of his illness, as he lay upon his sick bed, the interests of our local, national and international organizations were constantly in his mind and he referred frequently to plans and measures for their development and welfare. His election as President of the Institute in 1894, was a fitting recognition of his long and active service as a member of that organization.

Few American physicians have received such world-wide honors as has Dr. McClelland. Not only was he Honorary President of the International Homœopathic Congress when it met in Paris in 1900, but he was President of the International Congress in 1906, Hon. Vice-President of the British Homœopathic Association and President of the International Homœopathic Council in 1913.

In addition to his attending to the duties of a large and ex-



acting practice and his activities in medical organizations. Dr. McClelland was a liberal contributor to medical and surgical literature and many of his papers that have appeared in the transactions of the various medical organizations commanded widespread attention both at home and abroad and added greatly to the literature of our School.

Despite the incalculable loss that the death of Dr. McClelland meant to the community in which he lived and the homœopathic school throughout the world, it is as a kind and helpful friend that those who knew him best will most lament his loss. His firm adherence to what he believed to be right, his indomitable courage in overcoming what would appear to many to be insurmountable difficulties, his remarkable patience and his kindly councils won the admiration and affection of all who came in personal touch with him. His loss to the community, to the profession and to his friends is overwhelming.

G. H. W.

THE MANAGEMENT OF OCCIPITO-POSTERIOR POSITIONS.—Rice (New York) says the clinical picture offered by these cases should make us suspicious of the type of labor with which we have to deal. It consists, especially in primiparae, in early rupture of the membranes, either at the onset of labor or early in the first stage, a slow onset of labor, with nagging, weak and ineffectual pains continuing for several hours, later becoming stronger and characteristically more painful than in any other type of labor, exhaustion of the mother from long labor and constant backache, and slow dilatation of the cervix. If manual rotation is to be attempted it is advisable to make sure of the diagnosis by feeling an ear. In summarizing his article the author says the prolonged labor in occipito-posterior positions is due to early rupture of the membranes and maldirection of force. Prolonged labor is more common in primiparae. In primiparae with vertex presentation, early rupture of membranes is a very suggestive sign of occiput posterior positions. When the flexion is poor, spontaneous delivery can only occur after a long labor with strong pains. In multiparae relaxed pelvic floor is often a frequent cause of delayed rotation. In primiparae early rupture of membranes is the principal cause of prolonged labor. Double application of forceps offers the best method of delivery where the head is high in the pelvis. With floating head unless contraindicated, version offers the best solution in a flat pelvis. With head low in pelvis partial rotation by the blades is the best method. —*Amer. Jr. Obs.*, Vol. 66—232.

## GLEANINGS

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THE REMOVAL OF SUPERFLUOUS HAIR.—Calcium sulphide and anhydrous barium sulphide are suitable agents for the removal of hair, but that they have a less intense action than sodium sulphide. Ammonium sulphide is an excellent liquid depilatory and would be employed more frequently but for its unpleasant odor, all attempts to disguise it being unavailing. The following are two formulæ:

(1) REDWOOD'S.

℞ Sol. bar, sulphid, concentrat.  
Amyli q. s. ut f. pasta.

(2) DUHRING'S.

℞ Barii sulphidi, ℥iij;  
Pulv. zinc oxid.,  
Amyli, ää ℥j.

Duhring's formula is one of the best, but the sulphide should be fresh, otherwise its action is unsatisfactory. At the time of application, sufficient water should be added to make a paste, which is then spread over the hairy part and permitted to remain two or three minutes or until a sensation of heating or burning is felt. It is then quickly removed by scraping with a wooden spatula, and the skin is thoroughly washed with warm water; after drying, the skin should be covered with some cold cream.

In prescribing a depilatory, the patient should be informed that its action is only temporary, and that it must be repeated after a variable period. Further, when first applied, it should only be allowed to remain on the skin a short time, in order to ascertain the tolerance of the skin to its action, even if the removal of hair is incomplete.

*Hydrogen Peroxide.*—The bleaching properties of peroxide have long been used for changing the color of the hair, and advantage may be taken of this in connection with the growth of superfluous hair on the face of women. It is usual to employ it in those cases in which the hair is perceptible but too fine to admit of its removal by electrolysis; if used freely and repeatedly, a very material improvement in the appearance will be produced in a short time. Besides its bleaching properties, it has a destructive action on fine hairs, which after a time become brittle and break off, producing a still further improvement in the appearance.

Another advantage is a certain retarding influence which it exerts on the growth of hair, which after a while tends to become weaker, and

in some cases to stop altogether. It is a harmless remedy for home use, can be used without danger, and its results are good. It is of especial value to brunettes with fine dark down on the upper lip. It may be employed in a cream for night use, or dabbed on while dressing in the morning. After a few applications the hair is bleached white, and its occasional use afterwards is all that is necessary.

Merck's perhydrol is a good preparation of peroxide on account of its purity, but it should be diluted down to 10 volumes to begin with. It is expensive, and the ordinary peroxide is equally efficacious for dabbing on, but not if a cream is required.

The formula for a cream is as follows:

Perhydrol (Merck), 3ijss.

Adep. Lanæ anhyd, 3vj.

It is nothing like so rapid in its action, and does not keep long, but is less troublesome to apply. To obtain a quick result, it is necessary to use the plain peroxide and to clean the skin with a mixture of ether and spirit, in order to remove greasy substances from the hair, which prevent the peroxide coming into close contact.

Another method of applying peroxide, suitable for large areas, is by means of sodium peroxide soap, or pernatrol soap, which is obtainable in various strengths ranging from 2½ to 20 per cent. It should be left on the part for from five to twenty-five minutes, according to the tolerance of the skin. It is a suitable method for bleaching the hair on the arms and legs.

*Pumice-stone.*—Of the several palliative methods of treatment at our disposal, this is one of the simplest and by no means the least efficacious. It can be carried out at home, and is not at all harmful. The process is as follows: To commence with, the hair on the chin or lip should be cut short or shaved. A piece of pumice-stone without rough edges is selected, the artificial pumice-block being the best for the purpose, and rubbed gently over the part to be treated against the direction of the hair growth, for a few minutes twice a day; the friction should not be so severe as to damage the skin, and afterward a little cold cream should be rubbed in. This should be carried out for six months, during which time the part will be free from hair. A rest of a month is then enjoined, in order to see the effect produced on the hair growth: in a large number of cases it will be noticed that the hair growth is weaker—that is, where previously thick pigmented hairs grew, now finer hairs appear.

Another six months' rubbing is ordered, and at the end of this period, in some cases, the hair is practically destroyed, while the rest show a marked diminution in number and size of the hairs. After this an occasional rubbing will be sufficient to keep the growth invisible. Schwenter-Trachler has observed favorable results in 252 cases, over a period of ten years. There is no doubt that this simple method has some permanent effect, and should be tried when other means of treatment are not available.—*The Therapeutic Gazette.*



ARTIFICIAL PNEUMOTHORAX IN THE TREATMENT OF PULMONARY TUBERCULOSIS.—One of the most important factors in the treatment of any diseased organ is rest. As Forlanini has demonstrated, it is possible to compress a diseased lung by creating an artificial pneumothorax so that expansion is practically stopped. In the presence of hemoptysis it is effective in compressing the bleeding vessel sufficiently to control the hemorrhage. In cavity formation, if the cavity be not too large, it assists the coaptation of the walls of the cavity, and hastens the healing process. These four features accomplished, a marked improvement in the general condition of the patient ensues. Such satisfactory improvement has been noted in thirty-three out of some forty-four cases though no claims are made for complete recovery. Though originally indicated only where hemorrhage occurred it now appears so valuable that the method may well be employed in all cases of unilateral pulmonary tuberculosis, when no improvement seems to result from the ordinary treatment. It is obvious that inflation must be physically possible, that is the adhesions should not be so extensive as to prevent lung compression. If the patient shows signs of improvement under the artificial pneumothorax, it should be continuous. If the other side be affected and shows improvement, the treatment is to be maintained, otherwise it must be interrupted.

The pneumothorax is produced by the introduction of nitrogen gas into the pleural cavity. A needle is introduced into the free pleural cavity, and through this the nitrogen is forced under regulated pressure. There are certain dangers as air embolism and hemorrhage. As much as 1,000 c.c. of gas may be introduced at the first injection, though in many cases a few hundred cubic centimetres have had to suffice. Repeated injections are governed by the clinical conditions as indicated above.—*Fehliessen and Rothschild. Calif. Jour. of Medicine.*

THERAPEUTIC ANTITYPHOID INOCULATION.—When antityphoid inoculation was first employed as a prophylactic measure it was universally considered that the use of the emulsions in the actual disease could be followed only by harm. There was great fear that some might be treated during the incubation period, when, on account of the so-called "negative phase," the person might be rendered much more susceptible to the infection. The "negative phase" fear has subsided until it is now not recognized as of clinical importance.

W. H. Watters (*Medical Record*, Sept. 20, 1913) reports a total of one hundred and fifty-eight cases of typhoid treated by this means. These cases have been in all stages of the disease, incipient, moderately advanced, far advanced, in relapse, and moribund. In the entire number there were seventeen deaths, or a percentage mortality of eleven. Among these, however, were eight cases where for one reason or another but one dose of vaccine was given, and that when the patients were moribund or in extremis. Excluding these, there was a total of seven deaths in the remaining 148 cases, or a percentage mortality of 4.7 among those where the treatment "had a show." During this time a parallel series of 100 cases not receiving vaccines was watched, and here there were thirteen deaths, or a mortality of 13 per cent.

The advantage apparently lies entirely on the side of the vaccines. In no instance was he able to detect any injury or harmful effect from the treatment even in those cases in which there was no demonstrable benefit.

After analyzing the results in 1,120 other cases with 71 deaths reported by various observers he arrives at the following conclusion:

1. The best results have been attained by preparing the vaccine from an old non-virulent culture that has been sub-cultured for years in connection with the Widal tests. A new culture is made from this and incubated for twelve hours. In the fall of 1909 a fresh culture taken directly from a patient was used for several months. The cases treated during this time were apparently entirely unaffected by it in any way, following the usual untreated course. It was here that three of my seven fatalities in regularly treated cases occurred; not caused by the vaccines, but not in any way affected by them.

2. In comparing my dosage with that of others, it seems probable that mine may be increased to 100, 200, or possibly 500 million.

3. An early diagnosis of the disease is most important. This can often be first made by blood culture, days before the Widal reaction appears. It is probable that every day gained in diagnosis, and hence in the inception of the treatment, means several days gained in the duration of fever and appearance of convalescence.

4. The vaccines when properly used by an immunizator will do no harm in any stage of the disease or in a relapse. The earlier they are used, however, the greater may be the hopes of benefit therefrom.

5. A safe rule to remember is that the more severe the case, the smaller should be the dose. Amounts as small as one or two million have seemed to transform some most critical cases into convalescents.

6. The interval between doses is variable, averaging from two to four days. A dose or two administered after the temperature has reached normal will render relapses less frequent.—*Med. Rev. of Reviews.*

**AURICULAR FIBRILLATION.**—Zundel, in the *Clinical Journal* of June 4, 1913, says that the treatment of auricular fibrillation resolves itself into an observance of the general rules of treatment of heart-failure and the use of digitalis, strophanthus, or squills. The patient must, of course, be confined to bed. If cyanosis and right-heart dilatation are great, the abstraction of six ounces of blood by venesection or the use of leeches will often be of great help; apparently by relieving some of the distention of the heart, it paves the way for the action of the cardiac remedies. It is impossible to exaggerate the importance of rest, and both physical and mental calm should be secured. In this connection Zundel strongly advocates the earlier and bolder use of morphine in heart-failure. The dangers of this drug in these cases are not as great as has been supposed, and the benefit from its use is often great. A contraindication to the use of morphine is the presence of a pleural effusion reaching to the sixth rib posteriorly, or the occurrence of nausea and vomiting. In the absence of these complications, the restlessness of heart-failure, especially if accompanied by pain, is, in Zundel's opinion, a direct indication for the use of the drug. Attention to the bowels and the modification of the diet, so as to

avoid food which is indigestible or likely to give rise to flatulence, are as important as their necessity is obvious. Starvation for the first twenty-four or thirty-six hours is often beneficial, and is rarely resented by the patient. With regard to the aspiration of ascites and the puncture of edematous legs, these measures are seldom necessary, but if a considerable pleural effusion is present and the breathing is much embarrassed, it is a good practice to aspirate the chest. Especial care is necessary to withdraw the fluid slowly and without forcible suction, owing to the danger of syncope.

The drugs which are of value are digitalis, strophanthus, and squills. These have a similar action, but Zundel treats in detail of digitalis only, for it is the drug in most common use, it gives eminently satisfactory results, and it is free from some of the disadvantages of the others—*e. g.*, it is less nauseating than squills, and its liquid preparations are more stable than those of strophanthus. In patients who have a high blood-pressure digitalis is not contraindicated, for careful observations have shown that it does not raise the blood-pressure in these cases as was supposed.

Digitalis has the disadvantage of being somewhat slow in action. Therefore it is well, while commencing its administration at once, to give three or four hypodermic injections of digitalis 1-100 of a grain or strophanthin 1-150 of a grain during the first thirty-six hours.

Very satisfactory results follow the use of tincture of digitalis, in doses of 20 minims, three times a day. It is best given alone in water without any other drug. It should be continued until symptoms of intolerance appear, unless the desired therapeutic effect is obtained with a smaller quantity of the drug. The unpleasant effects which may arise are nauseating and frontal headache of varying severity. Should these occur the drug must be discontinued for over two days, and then administered again in smaller doses. A later effect, and one which shows that the heart is fully under the influence of the drug, is "coupling" of the beats. To detect this the heart itself should be examined, for the second beat of the pair is sometimes too feeble to reach the wrist, and an examination of the radial pulse alone would fail to reveal the condition present. This coupling need not be taken as an indication for withdrawing digitalis altogether, but when it occurs the dose should be reduced. The beneficial effect of digitalis is usually heralded by a striking fall in the pulse-rate; diuresis occurs only in those cases in which edema is present. Coincident with the fall of pulse-rate there may be some diminution of cardiac dilatation, but this is not constant and is often very slight. At the same time there is a great improvement in the subjective feelings of the patient.

The action of the drug may be either to control the fibrillation and restore the normal auricular rhythm, or it may be confined to a steadying of the ventricle by interference with the passage of the irregular impulses down the bundle of His. The first result, which is, of course, the more desirable, is hardly to be expected if the fibrillation has been of long standing; it is seen typically when the abnormality is quite recent and is occurring in an earlier attack of failure in a rheumatic heart. In the old fibrotic heart it is practically never obtained. By interference with conductivity, however, digitalis is able to exert a very beneficial effect upon



the ventricle. Owing to the partial heart-block produced by its action the ventricle is spared some of the continuous succession of irregular stimuli which come storming down upon it from the fibrillating auricle, and is able to recuperate more satisfactorily between its beats, which are, therefore, stronger and more effective. Indeed, so useful is this effect that patients may get up, take exercise, and even return to a moderately active existence in comfort with auricles that are still fibrillating provided that the ventricle is kept steady by the continuous influence of digitalis. For this purpose, small doses—*e. g.*, 5 minims of the tincture twice a day—may be sufficient, but the correct amount is easily found by experiment in any given case. So long as sufficient digitalis is given to keep the ventricular rate down to 70 or 80 the patient can continue in comfort even for years. The pulse in such a case does not become regular, but so long as it is not allowed to become rapid the patient can enjoy a comfortable and fairly active life. Such a state of affairs is often seen in elderly men in whom fibrillation has ensued upon chronic degenerative changes in the myocardium. It is also seen in rheumatic hearts where the abnormality has not been treated early and has become persistent. In early rheumatic cases there is a good prospect of complete restoration to the normal auricular rhythm, but a heart whose auricle has once been in a state of fibrillation is prone to further attacks of the condition and each attack tends to be more easily induced and to be more resistant to treatment than its predecessors.—*Therap. Gazette.*

DEHYDRATION TREATMENT OF BRONCHITIS.—Singer (*Deut. Med. Woch.*) reports several cases of bronchiectasis, fetid bronchitis, bronchial asthma, and abscess of the lung treated by systematic reduction of fluid in the diet. This treatment has long ago been recommended in acute coryza, but its advocates pushed it indiscriminately till it fell into disrepute. A too rigorous enforcement of the treatment not only is generally harmful but it even fails to give relief locally. The author prescribes a rich and varied diet, and begins the reduction of fluid gradually. He allows 230 to 400 c.cm. of water, milk, or soup every day for the first two or three days. Thirst is relieved by sucking a lemon, rinsing the mouth out with a dilute solution of eucaine, or taking a little opium. Twice a week, days of grace are allowed, when 1,200 to 2,000 c.cm. of fluid are given. During the treatment, which is usually kept up for four to six weeks, the patient first loses and then gains weight, and is heavier as a rule after than before the treatment. Besides the regulation quantity of fluid, a considerable amount is present in the cheese, vegetables, and stews prescribed. But though the treatment is not very heroic, it is contraindicated by renal disease or tuberculosis. The effect of the treatment is continuous after its conclusion, and, though its repetition may be necessary, the intervals between each course can be prolonged till further treatment is superfluous. This is the case both with functional disturbances of the bronchi and fetid bronchial secretion with definite lesions of the bronchi. The author gives a detailed account of nine cases illustrated by charts. One patient, a man aged 56, had suffered from cough and profuse expectoration since he developed bronchial catarrh four years earlier. Emphysema, diffuse bron-

chitis, and prolongation of the expiratory phase were observed. About 320 c.cm. of sero-purulent sputum were expectorated daily. Under the treatment this fell to 40 c.cm. in three weeks, Turkish baths being taken every other day further reduced the expectoration till it finally ceased. This course lasted from March 24th to May 22d. A second course was necessary from October 2d to January 10th, when 2,000 c.cm. of fluid could be taken daily without any resulting expectoration. When the weather became cold, cough and expectoration returned, but they were less troublesome than before, and were speedily checked by a renewal of the treatment.—*Charl. Med. Jour.*

TREATMENT OF GLANDULAR TUBERCULOSIS.—In a recent issue of the *Journal of Vaccine Therapy* appears a recent contribution of importance by Struthers Stewart upon the treatment of glandular tuberculosis. It is a summary of results in fifty-four cases of tuberculosis of the glands of the neck with tuberculin. It is of interest to note in this connection that Struthers Stewart always commences with the *small dose*, 1-200,000 mgm., increasing it gradually till a *slight reaction* is obtained, and the patient can stand 1-200 mgm. without any reaction.

A successful result after six months' treatment must be regarded as a favorable case; with mixed infection the duration of treatment will be much longer. He *prefers to deal with each organism separately; the administration of mixed vaccine has many disadvantages. It is impossible to say to which of the organisms the reaction is due, and therefore which should be increased, and there is less risk of development of hypersensitiveness to one or other of the vaccines.* In going over the splendid contribution of Stewart we are struck by its close parallelism to many of the basal truths of the distinctive Hahnemannian philosophy. To be more concrete, let us look at this contention *ad seriatum*—we have on the one hand the 1-200,000 mgm. of tuberculin to match off with the Hahnemannian *minimal* dose; (2) the slight reaction as a therapeutic guide to Stewart, alongside of what Hahnemann styled the *slight aggravation* induced by the proper choice of morbid agent; (3) the preference by Stewart to deal with each organism separately—cognate in the Hahnemannian sense to his choice of the *single remedy* in contradistinction to the markedly existent polypharmacy of his era. (4) A recognition on the part of Stewart of the futility of mixed vaccine, patent because of the impossibility to say to which of the organisms the reaction is due—this is germane to Hahnemann's epochal work on the *positive effect* of pure medicines; (5) the similarity of tuberculin as the remedial agency to the *indicated remedy* of Hahnemann based on his law of similia.

THE THROAT IN SCARLET FEVER.—Alexander Hittin, M. D., Brooklyn, N. Y., in an interesting paper in the October number of the *Medical Council*, Philadelphia, on the "Throat in Scarlet Fever," makes the following conclusions:

1. Examine the throat daily in every case of scarlatina, no matter how mild.
2. On the appearance of a membrane, make a culture to establish the identity of the causative organism.

**VACCINE THERAPY OF WHOOPING-COUGH.**—C. Nicolle and A. Conor recently presented before the Academie des Sciences, Paris, the results of their attempts at vaccination of whooping-cough by inoculation of living cultures of Bordet's bacteria, which they used during the epidemic which raged in Tunis last spring. These cultures on agar-potato-blood, made into an emulsion in physiologic salt solution were kept at 46 C. 114.6 F.) for thirty minutes, which does not affect their vitality, then repeatedly washed and centrifuged so as finally to obtain a perfectly homogenous emulsion of bacteria, isolated and deprived of all foreign substances. For use in vaccination, each drop of the emulsion (representing about 400 million bacteria) is diluted with 2 c.c. of physiologic salt solution. Because of the difficulty of intravenous inoculation of very young children, Nicolle and Conor inject it under the skin of the thigh, from 1 to 5 drops of emulsion each time. They have observed no general or local reaction. Of 122 children treated thus, 18 have not been seen after the first inoculation. Of the remaining 104, there have been 37 cures (complete cessation of cough), or 35.37 per cent.; 40, or 38.46 per cent., improved (notable diminution of cough) and 27, or 25.96 per cent., remained stationary. In the cases of cure, improvement became manifest very rapidly, generally on the first or the second inoculation. The nightly coughing spells diminished in intensity and number. Out of the 37 cures, 29, or 78.38 per cent., occurred after from two to five inoculations; that is, in from three to twelve days. In view of the often discouraging duration of whooping-cough, the results obtained by Nicolle and Conor are distinctly encouraging.—*Amer. Journal of Diseases of Children.* Reviewed by D. Braden Kyle, M. D., Philadelphia.

**VULVO-VAGINITIS IN CHILDREN.**—In a paper on "Vulvo-Vaginitis in Young Children," in *Archives of Pediatrics*, September, Nathaniel Barnett, M. D., of New York, recommends the following mode of treatment:

The mother is instructed at the clinic in the method of giving the vaginal douche and in preparing the permanganate solution 1 to 10,000. This injection is given daily. The patient is put on small daily doses of urotropin. In the clinic the patient is treated three times a week with the electric endoscope. The child is placed on the bedpan in the dorsal position, the foot of the table being raised at an angle of 30 degrees. This causes the cervix to come in line with the endoscope and simplifies the treatment.

(a) The external genitals are sponged off and the labia separated; (b) the Kelly endoscope is inserted as far as possible, the size of the endoscope depending on the size of the opening in the hymen and not on the age of the child. An endoscope of proper size should cause no pain—this is of the utmost importance. After one or two sittings the little patients will allow this procedure quite readily; (c) the obturator of the endoscope is withdrawn, the light inserted, and with no other manipulation than withdrawing the tube  $\frac{1}{4}$  to  $\frac{1}{2}$  inch, the cervix presents at the distal end of the tube; (d) any secretion is then removed with the applicator, and iodine (Lugol's solution) is applied directly to the cervix and vaginal walls as the endoscope is slowly withdrawn.

By this method of treatment cures can be obtained in a much shorter



period of time than with the ordinary irrigation of the vagina as the stronger solutions can be applied directly to the cervix and vaginal walls without causing pain.

The cases treated with the vaccines did show a complete cure of the arthritis, complicating the disease but did *not* show any improvement as to the vaginal discharge.

The prophylactic treatment is very difficult to carry out at home, but the following points should be insisted upon: Children should sleep alone; they should have marked linens and underclothes, which should not be used for the other children even after they are washed. They should wear a vulva pad, which is to be frequently changed. They should spread paper on the toilet seat, and they should keep their hands away from the genitals. Separate toilets should be provided for these children. Teachers and social workers should be taught that this disease is always present among children; they should be taught that there is such a thing as a vaginal gonorrhœal discharge, and that its method of acquirement in most cases is innocent.

INTERSTITIAL KERATITIS (CONGENITAL SYPHILITIC) TREATED BY SALVARSAN.—A series of ten cases of interstitial keratitis treated with salvarsan and neosalvarsan is reported. The ages varied from thirteen to thirty years, and duration of disease from four to thirty-two weeks. Adults were given full doses and children a proportionate dose, all intravenously, ten days apart and repeated three to six times. General mercurial treatment and local treatment to the eyes were also given. The results obtained from one or two doses were disappointing, but after the third and fourth injection the cornea began to clear, the pupil to dilate, and the ciliary injection and photophobia to subside. In some the clearance was so marked, once the process started, that difference could be noted daily. In only one case was the disease still fairly active at the end of the fifth injection. It is concluded that "606" and "914" are of greatest benefit in a considerable number of cases, very appreciably lessening the time of recovery, but may not prevent the affection involving the sound eye in monocular cases.—*Dr. G. F. C. Wallis, Ophthalmoscope.*

WILLIAM SPENCER, M. D.

A MICROSCOPIC STUDY OF THE CONJUNCTIVAL VESSELS.—With the aid of a Zeiss binocular microscope the author has carefully examined the conjunctival vessels. The most important observation concerns the vascular changes in arteriosclerosis. In the later stages of arteriosclerosis the retinal appearances are quite positive, but even then they do not permit an independent and conclusive prognosis concerning the general health of the individual. On the other hand, the changes in the conjunctival vessels are demonstrable as soon as their lumen is encroached upon, making it possible to discover the first symptoms of vascular disease. Furthermore, the signs are so clear and definite that they can be recognized unhesitatingly by any careful observer. Evidence obtained from any ocular symptom of arteriosclerosis is only of relative and corroborative importance.

Nevertheless, no clinician can afford to overlook what might be learned

by a careful study of ocular conditions, including microscopic investigation of the conjunctival vessels, in any case of vascular disease.—*Dr. W. H. Luedde. —The Amer. Journal of Ophthalmology.*

WILLIAM SPENCER, M. D.

CASE OF CONGENITAL NYSTAGMUS WITH MICROSCOPIC EXAMINATION OF EYEBALLS.—The patient was a child two years old, who died of pneumonia two months after examination. The eyes were removed and subjected to microscopic examination. On inquiry into the pedigree, no other instance of nystagmus was found. There was no consanguinity. Information showed that individuals with blue eyes and fair hair or both, formed a large majority on the maternal side and less than one third on the paternal side. There are no albinos. A number of individuals are mentally affected. Microscopic examination of the eyes showed no proper fovea in either eye. The association of nystagmus seen during life with abnormal appearance of each macula suggests to the writer the view that the retina is imperfectly differentiated at the fovea, which would thus explain the microscopic appearances. Whatever opinion may be held concerning the appearance of the retina proper at the macula, he believes that there can be little doubt that in this case the hexagonal cells in all parts of the retina are fully pigmented.—*Dr. C. H. Usher.—Annals of Ophthalmology.*

WILLIAM SPENCER, M. D.

TOXIC AMBLYOPIA DUE TO TOBACCO ALONE.—Patient showed V. R. 20-70, V. L. 20-200. Central scotoma for red. Temporal sides of the optic nerve heads were very white. Patient was an inveterate smoker, and seldom was without a pipe in his mouth. From his statement, and from investigation, it appeared that he had taken no intoxicating liquors of any kind for over forty years. Under total abstention from tobacco and strychnine injections, the vision improved to 20-10 with correction in each eye, and only a minute central scotoma for red remained in the left eye. This case is published to controvert the statement that it is doubtful if tobacco alone can induce disease of the papulo-macular bundle of the optic nerve fibres.—*Dr. Matthias L. Foster.—Archives of Ophthalmology.*

WILLIAM SPENCER, M. D.

THE PALLIATIVE TREATMENT OF OVARIAN CARCINOMA AND OF OTHER DOUBTFUL TUMORS.—Kroemer (Griefswald) says that primary ovarian carcinomata mostly come to the notice of the physician when ascites interferes with the patient's work. At this time the almost constantly present metastases in the omentum and peritoneum make the radical operation impossible. In spite of this the author recommends in such cases and by all means to perform laparotomy for the purpose on the one hand of becoming certain of the diagnosis, but on the other hand also for therapeutic reasons; for sometimes we have to deal with benign ovarian tumors or teratomata which possess the power of causing metastases which histologically are shown to be carcinomatous. Two such cases which seemed to be doomed and in whom a radical operation was impossible, were again able to perform the duties of their usual occupation after the

removal of undoubted carcinomatous nodules in the omentum, and the removal of ascites and permanent drainage through the abdominal walls, and one of the patients remained free from recurrence for two years. Such cases, therefore, which cannot be operated radically, should not be regarded as hopeless although they may not be regarded as favorably as benign pseudomucin cysts, whose adenomatous implantation metastases spontaneously disappear after removal of the primary tumor, other instances of which the author cites. The author summarizes the various palliative methods of operation as: (1) a drainage fistula for the ascites; (2) entero-anastomosis if ileus appear; (3) removal of the primary tumor and leaving the metastases; (4) removal of the metastases and leaving the primary tumor.—*Abstr. Zentralbl. f. Gyn.* 1913—72.

THEODORE J. GRAMM, M. D.

**HYPEREMESIS GRAVIDARUM.**—Stolz has written an excellent summary of our present knowledge of this perplexing condition. While not exactly denying the intoxication theory, he seems to believe that by reason of the increased nervous sensibility of the pregnant woman, she is unable to meet the greater defensive demands made upon her system and suffers in consequence. As furnishing some proof of this view he points out that severe cases are generally found in highly nervous women. We possess two means of treating this disease. Either the cause of the intoxication must be removed by emptying the uterus or we must suppress the sensibility of the organism so that the nutrition and general strengthening of the organism are increased so that the intoxication may be overcome. In the few cases where induced abortion failed, it was performed so late that the organism could not recover. In the symptomatic treatment it is not sufficient to remove abnormal conditions in the genital organs, nor to treat the vomiting with cerum oxalate, orexinum hydrochlor., cocaine hydrochlor., sodium bicarb., etc., which generally fail. Sedatives and narcotics should not be given by the mouth because they undergo changes before their absorption. The author believes it best to diminish nervous sensibility by the subcutaneous or rectal administration of narcotics and sedatives in increasing doses. In addition the author advises that the patient be kept in bed, be protected against nervous impressions of every sort, and to take mostly cold, easily digestible food in small quantities. He also advises that the bowels be moved regularly, and that the patient be given protracted enemata of salt solution.—*Abstr. Zentralbl. f. Gyn.* 1913—91.

THEODORE J. GRAMM, M. D.

**SOME DIAGNOSTIC PITFALLS IN ABDOMINAL SURGERY.**—Hedges (Plainfield, N. J.) says beware of diagnosing cholecystitis in the young. They rarely have anything the matter with their gall bladders. When a boy or a girl complains of pain in that region, with fever, tenderness on pressure with rigid muscles, look out for central pneumonia with diaphragmatic pleurisy. Watch the fever. It will be more regular and less of the intermittent type, the pain will be steadier and while there may be no cough nor increased respirations nor any pulmonary symptoms, but in five or six days the physical signs of pneumonia will appear.



There is danger of confusing a beginning pneumonia with appendicitis, especially in children, because the lower intercostal nerves have branches running down to the skin and muscles of the abdomen, so that irritation within the chest is felt in the terminal filaments of these nerves in the region of the McBurney's point, giving rise to pain, tenderness and rigidity in that region. In pneumonia the fever is higher in the beginning, with increased respiration and a higher leucocyte count. The main point is always to make a careful examination of the chest before diagnosing appendicitis in children.

Many digestive symptoms come from chronic appendicitis. In every intractable dyspepsia unless we can satisfy ourselves as to its cause we should suspect the appendix even though no marked local symptoms have appeared in that region.

Of floating kidney the author says the majority of women who have movable kidney have no symptoms arising from this condition. If there are paroxysms of pain due to kinking of the ureter or of the pelvis of the kidney, and during these attacks of pain or just afterward marked urinary changes occur, then we are warranted in fastening the kidney. Morris has recently called attention to the valuable diagnostic point that when a floating kidney is causing trouble there is a splint-belly rigidity of the muscles overlying the organ, on the same principle that the rectus protects an inflamed appendix.

In every case of intestinal obstruction thoroughly inspect all the hernial outlets. Frequently a small knuckle of gut, so small as to escape detection from a casual look, gets caught in one of these places, gives no pain at the point of constriction perhaps, but causes epigastric distress, and unless we carefully examine the hernial exits we may mistake the site of the trouble.—*Amer. Jr. Obs.*, Vol. 67—288

THEOPHORE J. GRAMM, M. D.

THE CHRONICITY OF APPENDICITIS.—Jacobson (Toledo, O.) says every surgeon who has had much experience in abdominal surgery must have been impressed with the frequency or the almost constant presence of pathological changes in and about the appendix apparently without the slightest history of such involvements. This is true of the operations performed for the so-called first attack of appendicitis and is especially true in the routine examination or removal of the appendix in conjunction with other abdominal operations. In 100 operations for appendicitis the author had 31 operations for supposed first attack of appendicitis. In 50 per cent. of these there was unmistakable clinical evidence of previous inflammation of the appendix. In the last 100 abdominal operations in which the appendix was removed as a routine procedure, pathological changes were found in 54 per cent. of the cases. The author summarizes his article by saying that infection of the vermiform appendix is of enterogenic origin, and as a rule is a slow process resulting from stasis of intestinal contents in the cecum. Appendicitis is essentially a chronic disease. Chronic inflammatory changes in the appendix usually precedes the acute attack. Stasis in the cecum is favored by the antiperistalsis of the ascending colon in combination with a mobile cecum or adhesions about the ileocecal junction.—*Amer. Jr. Obs.*, Vol. 67—493.

THEOPHORE J. GRAMM, M. D.

## Monthly Retrospect

### OF HOMOEOPATHIC MATERIA MEDICA AND THERAPEUTICS

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CONDUCTED BY DR. DONALD MACFARLAN  
PHILADELPHIA

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**FERRUM.** Dr. T. G. Stonham contributes an excellent article on *Ferrum* in the *Homœopathic World* of July 1st, 1913. The indications for its salts are also well discussed by him. The following are some of the most important features of Stonham's original communication:

Pure metallic iron exists only in very small quantities on the earth's surface, but in its various ores, mainly oxides, carbonates and sulphides, it is the most abundant as it is the most important of metals. It is a normal constituent of the human body, in which it is present to the amount for forty to fifty-five grains. It is an important element in the hæmoglobin of the blood and is a never-failing constituent of the nucleins and nucleo-proteids, and therefore is present in the leucocytes, and in a very small extent in the blood serum. It is probably essential to the life of all forms of protoplasm, whether animal or vegetable, and in the higher plants chlorophyll cannot be formed in its absence, although chlorophyll itself does not contain iron. Though the larger part of iron in the human body is taken up in the formation of hæmoglobin, it enters also into the composition of some oxidases, and probably performs a role as an oxygen carrier in certain cases. It is found in the spleen and the liver, the latter of which acts as storehouse for any excess above the requirements of the body.

The ovum contains all the mineral bodies necessary for the development of the young animal, and the nucleo-albumin containing iron is the substance from which the hæmtogen used in the formation of hæmoglobin is formed. In this connection it is of interest to note the richness in iron of the liver of new-born animals. In the cow foetus the amount is ten times as much in proportion as in the adult cow or ox, and the liver cells of a calf a week old contain seven times as much iron as the adult animal. The quantity decreases in the first four weeks of life, and at the end of that time reaches about the same proportionate amount as in the adult. The foetal liver cells, therefore, bring an abundance of iron into the world to be used up shortly after birth for a purpose not well known, but which one may conjecture is related to the establishment of ærial respiration, in which function hæmoglobin plays so important a part.

Iron is present to a small amount in all foods, varying from 1.4 to 1.7 milligrammes per 100 grammes of substance in white bread, 2.3 milligrammes in milk, 6.2 milligrammes in potatoes, to 40 milligrammes per 100 grammes of substance in spinach. The common dock, *rumex obtusi-*

folius, contains as much as 0.447 per cent. of iron, a proportion greatly in excess of that found in any other plant. The iron is present in organic combination analogous to the ferric derivatives of the nucleones. A preparation of iron with nucleins as a base has recently been obtained, which contains as much as 8 per cent. of iron. It is called *fer. ascoli*. The average quantity of food iron in a mixed dietary does not exceed one-twelfth to one sixth grain a day, and this small amount suffices to maintain the iron equilibrium of the body. Any excess of iron in the blood is got rid of mainly by excretion from the cæcum and large intestine; very little is excreted in the urine, not more than 1 to 2 milligrammes a day; a small quantity is found in the bile, which contains it to the extent of 0.04 to 0.115 per mille, chiefly combined with phosphoric acid.

When a large quantity of iron is given by the mouth it can nearly all be obtained again from the fæces. What takes place is as follows: The iron preparations given by the mouth are in the stomach partially changed to the chloride and then to the albuminate, and pass on to the duodenum, from which the great bulk is carried on to the lower part of the intestines and discharged from the rectum with the fæces, which are black from the presence of sulphides of iron. A small portion is absorbed by the intestinal epithelium and taken up by the leucocytes, which carry it either in solid form or solution to the spleen, where it may undergo some changes, and whence it is taken up by the blood and deposited in the liver and perhaps in the bone marrow. In the liver it is stored for a time, and, if wanted, is worked up into higher forms, and eventually to hæmoglobin. Ferratin is probably one of the intermediate forms, as this is found in quantity in the liver. When there is no deficiency of iron for the formation of hæmoglobin, the liver slowly yields its store of iron to the blood, which carries it to the cæcum and large intestine by the epithelium of which it is excreted. The quantity of iron in the urine and bile is not influenced by the amount of iron absorbed. The liver acts as a storehouse for iron injected hypodermically, and is also the repository for the iron set free in the destruction of red blood corpuscles. A destruction of blood pigments, with a splitting off of compounds rich in iron, seems to take place in the liver in the formation of the bile pigments. Even in invertebrates, which have no hæmoglobin, the so-called liver is rich in iron, from which Dastre and Floresco conclude that the quantity of iron in the liver of invertebrates is entirely independent of the decomposition of the blood pigment, and in vertebrates it is in part so. According to these authors the liver has on account of the quantity of iron in it, a specially important oxidizing function which they call "function martiale" of the liver.

Iron is not absorbed from the unbroken skin. When an inorganic iron salt comes in contact with the tissues it immediately forms an albuminate, liberating the acid with which it is combined. The albuminate is insoluble and forms a protective coating over the tissues to which the iron salt has been applied. Iron has no corrosive action of itself, and therefore any destructive action caused by such salts as the perchloride is due to the liberated acid ion. The formation of an insoluble iron albuminate is the rationale of the use of iron salts as styptics; a plug of iron albuminate is formed that seals the mouth of the bleeding point. As it is necessary that the iron salt should be brought into actual contact with the bleeding



point, it is the most useful for capillary hæmorrhage from parts that can be easily seen and reached. The perchloride has been used as an injection into the uterus to arrest post partum and other hæmorrhages, but this is a most dangerous proceeding, and several cases of fatal embolism have occurred from the precipitated iron albuminate being carried off in the veins. Its employment to cause coagulation and subsequent cicatrization in nævi is open to the same objection. The double salts of iron, the albuminous compounds, and organic iron do not precipitate proteids and are, therefore, neither irritant nor astringent.

The great sphere for the therapeutic employment of iron is the condition of anæmia, and especially of anæmia due to deficiency of the hæmoglobin of the red blood corpuscles, viz., chlorosis. All schools of medicine use iron in anæmia, and obtain good results. It will cure cases to which iron cannot be said to be strictly homœopathic. Being one of those substances which are an essential constituent of the body, its action is not limited, as is a foreign body, like aurum, for instance, to exciting certain reactions in the cells in its rôle as a stimulus, but it also is necessary to one of the body tissues, viz., the hæmoglobin. It might be supposed therefore that iron cures anæmia by supplying to the blood a substance in which it is deficient. No doubt this is so, but it cannot be the whole explanation. An ordinary diet contains plenty of iron for all the needs of the economy. The fault in anæmia must lie not in the lack of sufficient iron in the food, but in the inability of the organism to assimilate it. The question then arises why the ingestion of an additional quantity of iron should stimulate to an increased assimilation organs too feeble to cope with the amount they have already to deal with. It is hard to say, but judging from analogy it probably does so. It seems to be a fact that the organism is, within limits, able to make increased efforts in response to increased demands. A muscle becomes larger and stronger to meet the requirement of heavier work; the heart hypertrophies to meet the demands of an increased circulation or increased peripheral resistance; the remaining kidney, after one has been removed, enlarges to enable it to take on the work of its fellow, and the stomach and intestines increase their secretions in order to digest a larger amount of food. The increased work demanded is itself a stimulus. In the same way, when the parts of the organism concerned in the elaboration of iron for hæmoglobin have an increased amount of iron given them to work up, they are stimulated by that very increase to rise to the occasion, even though previously they have been languid and inefficient. The process once set going, may so renew the general health as to take away the conditions which originally caused the anæmia. If this happens the improvement will be permanent, but if the original cause of the anæmia, whatever it may be, remain, a relapse will sooner or later take place. A fresh stimulus from more iron may again cause an improvement, but the oftener this is repeated the less becomes the effect produced, till at last no response occurs, the iron assimilating function has become utterly exhausted. The case of anæmia is then most intractable, for the power of assimilating iron has become, for a time at any rate, destroyed, and the treatment has made the patient worse than he was at the beginning.

We see a similar exhaustion occurring from over-stimulation by excess of pabulum in the case of other constituents of the body, e. g., chlor-

ide of sodium. A person who habitually takes too much salt may cause in himself a train of symptoms indicative of a want of salt in the cells, although the fluids by which cells are bathed may be saturated with it. Therefore, unless a case of anæmia is one to which ferrum is homœopathic, iron must be used cautiously, for if it fails to act as a stimulus when given in bulk it is likely to fail badly. When, however, the case is one to which ferrum is truly homœopathic it can be given without any fear of evil consequences and with certainty of curative effect. It is then given, not in bulk but in minute doses, and acts, not by a call to increased effort on the part of the iron-assimilating function, but by a subtle rectification of vital processes. To ascertain to what cases of anæmia ferrum is homœopathic we must study the provings. These are recorded in the "Cyclopædia of Drug Pathogenesis." Hahnemann himself, and three others, made the original provings, and their 261 symptoms, with thirty-seven from seven authors, are recorded in the *Materia Medica Pura*. Provings were also made by five of Rademacher's followers and by the American Provers' Union. Hahnemann's proving was made with the acetate.

The first effect experienced by the provers was a feeling of increased energy and well-being, with some fulness and heat in the head, and much increased appetite, but this was soon followed by the reverse condition of loss of vigor, lethargy, a tired feeling and a tendency to chilliness. The effect on the mind after the primary condition of buoyancy was to induce ill-humor, a looking on the dark side of things, a tendency to exaggerate trifles, and an impatience of obstacles and hindrances which unduly annoyed. The provings further showed that with ferrum the circulation is irregularly excited, giving rise to arterial congestions with dilatation of the blood vessels. From this latter cause pulsation may be felt in special localities or all over the body (Puls., Glon.). The pulse is full, soft, and of low tension, differing from the typical aconite pulse, which is tense and bounding. The arterial congestion is felt most in the upper part of the body, in the head and chest. The headaches are congestive and throbbing, and are felt especially in the forehead, but there may also be aching and fulness in the occiput with an aggravation on coughing. Giddiness, with a tendency to fall forward and which is worse on descending (Borax), and a balancing sensation when looking at running water. The headaches are worse from movement, especially on rising from a lying position, and worse from mental exertion; they are relieved by pressure and by cold air and cold bathing.

The face flushes easily from pain or from the least emotion, and a red face accompanies the headache, the redness often being circumscribed, and though the face is hot it is less hot than red. When there is no pain or emotion the patient's face is pale, ashen, or earthy, but it flushes at the least provocation. Another symptom indicating rush of blood to the head is epistaxis, which occurs usually from one nostril only. There may also be buzzing in the ears.

The arterial congestion produced by iron in the chest is shown by an oppressed constricted feeling over the sternum with sensation of want of air various shifting pains in the chest, and an irritable cough from tickling in the larynx or behind the sternum, better from lying down and from food, worse from movement. The congestion may be sufficient to induce hæmop-

tysis, either of pure blood, or of blood mixed with mucous expectoration. With each cough there is often pain in the occiput. Another ferrum cough one associated with digestive disturbance, it is excited by a meal, and is associated with vomiting of food. The cardiac disturbance is shown by palpitation, which is worse from sudden motion, but like many other symptoms of ferrum is relieved by walking slowly about (Gels., Magnes. mur.). The excited condition of the circulation underlying these head and chest symptoms is not long sustained, but alternates with the reverse condition of anæmia of those regions; the arteries from being too full, become too empty, there is pallor, and the blood tends to accumulate in the veins, producing a venous plethora such as is characteristic of pulsatilla.

It is well known that the salts of iron are liable to upset the digestion and to injure the teeth, and it is largely on this account that the organic preparations of iron have been introduced to medicine as they exert no local action on the teeth and mucous membranes. But iron causes symptoms referable to the digestive tract apart from any topical action. The tongue is coated with a white or brownish fur. The taste is bitter, or sweetish, as from blood, or of rotten eggs. The appetite is capricious; there may be ravenous hunger, which was the first effect experienced by many of the provers, or there may be complete anorexia; similarly there may be unquenchable thirst, or thirstlessness, and these states may succeed one another. Longing for acids or for beer, which disagree; appetite for bread and desire for stimulants which agree. Distaste for meat, which lies hard and heavy in the stomach. Eggs disagree and often cause vomiting. This is interesting, seeing that the hæmatogen found in the yolk of the egg is an organic iron compound. Food is preferred cold. Eructations, sour or bitter. Food lies heavy in the stomach and causes pressing or cramping pain. There may be vomiting which occurs immediately the food is taken, or it lies for hours in the stomach to be finally vomited, often at midnight. The abdomen feels hard and distended and sore as if bruised. Frequent rumblings and pinching pains, relieved by evacuation of stool and wind. The primary action of ferrum is to cause a more frequent action of the bowels or diarrhœa, which is excited by taking anything into the stomach, so that we get the singular symptom "diarrhœa while eating," which is characteristic of ferrum. If there is no looseness there may yet be frequent ineffectual urging to stool, and in children this may cause prolapsus recti for which ferrum is a good remedy. The diarrhœa stools often contain undigested food, or they may be slimy or bloody. Constipation is a secondary symptom; it may be accompanied by bleeding hæmorrhoids and evacuation is followed by painful backache. These symptoms occurring in the alimentary system, are common in anæmia, and it is in cases where there is a deficiency in the hæmoglobin of the red corpuscles, and where the circulatory and alimentary symptoms described above are present that ferrum is homœopathic to anæmia, and will cure it in infinitesimal doses. Farrington recommends ferrum in the gastro-enteritis of children stools, when the stools occur about midnight. 12 P. M. is one of the times of aggravation of ferrum, and applies both to vomiting and diarrhœa.

The irritability of the bowels has its parallel in irritability of the bladder. There is a greatly increased desire to pass water with difficulty, in some instances in retaining it. This is experienced whilst standing



or walking, and is relieved by lying down, when the pressure of the urine is taken off the neck of the bladder. The incontinence is diurnal only, and this peculiarity is the indication for its use in incontinence of urine in children, and in the diurnal weakness and incontinence that occurs in old men with enlarged prostates, and is probably due to the congested condition of the veins about the neck of the bladder. The picrate of iron is best in these cases.

In the female sexual system the chief symptom produced is menorrhagia. The menses are too late, too long lasting, and too profuse; the flow is of pale, watery, or of bright red blood, often mixed with coagula. The menses are apt to intermit two or three days and then return; they are preceded by headache with ringing in the ears and flushed face, also by leucorrhœa. There are physical languor and mental depression, and during the first day or two, bearing down with sharp pains in the abdomen. Pain in the os uteri on lying down. The cases of menorrhagia for which iron is suitable, generally occur in anæmic girls with bright red cheeks, the menorrhagia being the cause of the anæmia, and the phosphate is the salt most needed in these cases. Ferrum is also useful for amenorrhœa when the amenorrhœa results from the kind of anæmia to which iron is homœopathic, viz., anæmia with irregular circulatory disturbances, red flushed face, pallid mucous membranes, breathlessness, and with red corpuscles deficient in hæmoglobin.

Ferrum causes a few rheumatic-like pains in the limbs, notably in the shoulders and upper arms, and has a special relation to the deltoids, paralysis and wasting of which it has cured. The pains are often paralytic (benumbing), are worse at rest and better for slow movement.

The fever of ferrum is characterized by thirst and red face occurring during the chill. The perspiration is copious, has a peculiar odor, and stains yellow. The general characteristics of ferrum are excessive irritability of mind and tissues with over sensitiveness to pain and to noises; a restless feeling, must keep the limbs moving. The symptoms mostly come on during rest, and though they are aggravated by any sudden or violent movement, they are usually relieved by walking about slowly. They are apt to come on at midnight, or soon afterwards. The patient dislikes the cold and cold weather and likes to be in a warm room, and in warm air, the pains are better for warmth, except those in the head, face, and teeth, which are relieved by cold and in the open air. The asthmatic breathing also is relieved by uncovering the chest. There is general or local pulsation and the pains take on a throbbing character. Congestions tend upwards with hot head, red face, and cold feet and hands.

Ferrum is often indicated in complaints caused by loss of animal fluids, and is antidotal to the effects of quinine, tea, and alcoholic drinks.

The iron element so overshadows the acid in the salts of iron that there is very little difference in their pathogeneses and therapeutic applications. The principal salts used in medicine are as follows:

*Ferrum Arsenicum.*  $\text{Fe}_3,2\text{AsO}_4$ .

This salt combines the properties of iron and arsenic. It has been used successfully by Dr. P. C. Majundar in cases of enlarged liver and spleen, with fever, in malarial cases that had been suppressed but not cured by quinine.

*Ferrum Bromatum.*  $\text{FeBr}_2$

This was proved by Dr. Sarah N. Smith, of New York, in the sixth dilution, and caused in her much heaviness and weight in the uterus with sticky excoriating leucorrhœa; also numbness of the scalp. It would be indicated in uterine congestions.

*Ferrum Iodatum.*  $\text{FeI}_2$

The iodine element in this salt is shown by the profuse nasal discharge, and by the more pronounced amelioration in the open air and the aggravation from warmth. It corresponds more particularly to scrofulous affections, to glandular enlargements and to tumors. It has an influence on the ovaries, and there are bearing down, retroversion, or prolapse of the uterus, and leucorrhœa like boiled starch. Peculiar symptoms of  $\text{FeI}_2$  are "food seems to push up into the throat as if it had not been swallowed"; "sweet smelling urine," and a boring, twisting sensation in the rectum.

Dr. P. C. Majundar has used it with success in cases of enlarged liver and spleen unaccompanied by fever (with fever *Fer.-ars.*).

*Ferrum Magneticum.* Sesquioxide of Iron.  $\text{FeOFe}_2\text{O}_3$

This is practically identical in symptoms with *Fer. met.*, *Fer. carb.* and *Fer. acet*

*Ferrum Muraticum.*  $\text{FeCl}_2 \cdot 4\text{H}_2\text{O}$ .

A solution of this salt is the old "steel drops" so much used formerly in anæmia. It is also the iron salt most frequently used as a local application to arrest hæmorrhages. It is mainly a right-sided remedy and is more apt to produce hæmorrhages than others of the iron salts, except the phosphate.

*Ferrum Pernitricum.*  $\text{Fe}_2,6\text{NO}_3$

This has been used as an astringent in cases of diarrhœa in phthisis and scrofulous children.

*Ferrum Phosphoricum.*  $\text{Fe}_2(\text{PO}_4)_2$ .

*Ferrum Phosphoricum Hydricum.*  $\text{FeHPO}_4$

The first of these is Schussler's ferrum phosphoricum. The phosphorus element accentuates the tendency to bleeding due to the iron. *Ferrum phosphoricum* has been used by Schussler in the place of aconite in inflammations. The chief difference between the two drugs is that with aconite the pulse is tense and bounding, while with ferrum phos. it is full and soft. The mental anxiety and restlessness characteristic of aconite are less in evidence. *Ferrum phos.* is a notable mineral constituent of aconite. The aggravations from cold are marked.

*Ferrum Picricum.*  $\text{C}_6\text{H}_2(\text{NO}_2)_3\text{OFe}$ .

This drug was introduced by Cooper. It has not been proved, but has definite leading indications, the picric acid element giving it distinguishing features. It acts on the liver and is suitable for persons with dark hair and eyes, bilious-looking, and with dirty looking skin, especially about the joints. It is especially indicated for warts on the hands. Cooper used it for "vascular" deafness, and it cures boils in the meatus of the ear. It has a specific action on the prostate, and is beneficial in senile hypertrophy of that organ. Effects of fatigue.

*Ferrum Protoxalaturn.*  $\text{C}_2\text{O}_4\text{Fe}$ .

This has been much used by Dr. Galley Blackley's recommendation for anæmia.

*Ferrum Sulphuricum.*  $\text{FeSO}_4 \cdot 7\text{H}_2\text{O}$ .

The sulphuric acid character appears in the acidity, and in the eructations of food in mouthfuls.

**HOMŒOPATHY IN BRAZIL.**—At the present time, when the eyes of all are more or less fixed on the turn of affairs in Central and South America, both as regards the opening of the Panama Canal and the present crisis in Mexico, it may not be amiss to discuss the Brazilian situation of homœopathic progress as detailed in a recent address at Ghent by Dr. Vasconcellos. The following data are entirely based upon important addresses delivered in French by Dr. Vasconcellos, of Rio, at the International Homœopathic Council, which was held this year at Ghent. Brazil has a large number of devoted and convinced members of our school of practice. The knowledge of its truth was derived entirely from great European and German medical men. In Brazil itself, Dr. Mure was one of the greatest, and Dr. Vasconcellos was pleased to link Brazil with a world-wide homœopathy by means of this Congress. (In many respects, Dr. Mure bore striking resemblance to Adolphus Lippe, a German nobleman who at an early age left his native land to come to this country. The latter, later became intimately associated with Constantine Hering.)

Owing to want of knowledge on the part of the executive of this recent Congress, Dr. Vasconcellos was present as a private delegate. Had the council communicated directly to the Minister of Public Instruction, he would have been there as the official representative of the Brazilian Government. Next year suitable approach of the Minister will secure this. As early as the year 1818, the power of homœopathy was beginning to be felt in Brazil, as shown by the opposition to its tenets and its upholders. This power was greatly added to, by the arrival in the year 1840 of Dr. Mure, and by the co-operation with him from the surgical side of Dr. S. Martinho. Dr. Mure was chiefly a physician and an authority on *materia medica*, and is known in Great Britain by his writings and his translations. His was a most interesting personality. A French merchant, he was cured at Lyons of a lung affection and became so much interested thereby in the art of its practice that he graduated in medicine at Montpellier and earnestly worked for the spread of its teachings in France and subsequently in Brazil. In 1839, he assisted in the establishment in Paris of a Homœopathic Institute and a homœopathic dispensary and library. At the opening of the Institute, Hahnemann himself was present. Arrived in Brazil, Dr. Mure tried to convert allopathic doctors and in new areas he appealed to the priests in the name of charity and Christianity. The efforts of these pioneers in homœopathy were successful in forming a society called the *Instituto* of Homœopathy in the year 1843. Two years later, there was established a School of Homœopathy, which, however, like its compeer in London, had to be but a temporary establishment.

In 1846, however, it was granting certificates but these did not rank with the Government diploma, only obtainable through the allopathic colleges. The applications of the homœopaths for the power to grant diplomas, raised a storm of opposition and a struggle arose in the ranks of the Academy of Medicine and outside, resulting in a defeat of the homœopaths. The calm after the struggle was accepted by them, however,



as a period for organizing their forces. The school continued to teach though its pupils received no official recognition. Within the year 1855, came that fell disease cholera to the city of Rio. Then and there the homœopathists met their opportunity and embraced it. The result was not different there in the new western world from what it had been in Europe, in England at a slightly later date, and in the great Eastern Empire of India, where it is more or less endemic. The mortality of the homœopathists was as usual about one half of that of the allopathic practitioners. The result was the renaissance of homœopathy. In 1859 took place the reorganization of the Institute of Homœopathy, a nucleus of the later developments of which Brazilian homœopathy is so justly proud. The rest of the story is quickly told. Soon after this occurred another of those tides which taken at the flood, lead on. Again the hour and the man met. Dr. S. Merelles was not only a good homœopathic medical man but a good engineer, and a professor in the Naval College.

At this time the Minister of War was taken ill, and his case rapidly developed and was pronounced as fatal by the attending physician. So sure was he that the minister must die that he readily resigned the case to the homœopathic physician who was called in. The Minister of War recovered under the care of Dr. Merelles. There soon followed on this, the official recognition of homœopathy. A homœopathic dispensary and the pharmacy in the General Hospital was handed over to the homœopathists. For teaching purposes some desired the establishment of a chair of homœopathy in the medical faculty ranking with other branches of medical science. Shortly after this Dr. Licino di Cardova followed in working for the homœopathic interests. In his day notable advances were made. Equal rights with the allopathic physicians were demanded and conceded. One reason of the ready granting of this request was that it had been shown that veterinary homœopathy had proved better and cheaper in cost than allopathic treatment. The Brazilian homœopathists have quite recently been recognized as a responsible educational faculty with power to grant degrees on equal terms with the allopathists.

A sum of fifty thousand francs was accordingly quite recently voted by the Government in support of homœopathy. There is thus a prospect of a steady and increasing supply of qualified homœopathic physicians. At present there are over a hundred avowed homœopathists in Brazil, a third of these being in Rio de Janeiro. There are fifty homœopathic pharmacies. These get their remedies chiefly from Germany and the United States. All up the valley of the Amazon the Hahnemannian doctrine is spreading. There are in addition over eighty unattached homœopathists who have studied and spread abroad in Brazil. In each of ten or twelve general hospitals there is a homœopathic section. In the army there are homœopathic doctors officially recognized and eligible for military and state honors. In the Empire and the Republic of Brazil homœopathy has progressed with the greatest rapidity. For the data detailed above Dr. E. A. Neatby, of London, has to be thanked.

*PLUMBUM AND PLUMBISM.*—Two articles of recent date have appeared on lead-poisoning. One article is the contribution of Sir Thomas Oliver, in *The Lancet*, and pertains rather closely to the preventive and curative

aspect of this industrial disease, whilst the other article, from the pen of Dr. J. Stanley Kenney, of New York, deals with the study of some thirty cases with reference to industrial hygiene. Both observers speak about the characteristic symptoms of the disease. In going through a lead-works, as Sir Thomas Oliver sees it, one is at once struck by the pallor the sallowness, the cachectic appearance, and the expressionless features of the workmen. They have not the appearance of healthy men. They differ from groups of workmen in other trades. In speaking to these lead workers there is detected a distinct tremor of the nasolabial muscles of the face and on examining the mouth a blue line may or may not be seen on the gums.

In the urine of these men lead in minute traces may be found. Many, although looking pale and sallow do not complain of feeling ill. They may go on with their work for months or years until something happens, such as a cold or influenza or even a possible debauch, when, without any explicable cause other than a derangement of their emunctories those men who have been following their trade with due regularity, are stricken down. All at once or gradually, they complain of colic, develop a wrist-drop, or otherwise evince some sign of a lead poisoning. Dr. Stanley Kenney, in his remarks bears strikingly upon the symptomatology of cases studied in private practice and also those detailed at the Cornell University Medical College Dispensary. Although Dr. Kenney does not summarize the relative frequency of the symptoms elicited, this is readily arrived at, and brings forth the following data. In the thirty-five cases, eighteen showed a distinct lead-line, while twenty-five complained of constipation and twenty-three of colic. Six had either wrist-drop or weakness of the wrist, whilst tingling, numbness, and pain or tremor in the extremities were seen in a lower percentage of cases. The blood picture was very interesting: fourteen of the thirty having a prominent anemia. In twelve cases a characteristic basophilia was noted while five had a hemoglobin index lower than seventy-five per cent. Vomiting and granular kidney were quite frequent as was arteriosclerosis. Quite a number of other symptoms were seen in individual cases, but the above are the more dominating disease-producing effects caused by this drug.

The above prominent symptoms grouped more or less together *in toto* present a congerie of symptoms unmistakably bespeaking the case of one having undergone the noxious influence of a lead poisoning. It is, however, just this contingent susceptibility of those poisoned and brought under our notice which makes these cases so valuable as affording indications for the homœopathic use of plumbum. During the course of many disease-states, conditions arise simulating the colica pictonum or painter's colic due to lead-retracted abdomen, abdominal pains radiating from the umbilicus and supposed to be due to over-excitation of the intestinal ganglia, obstinate constipation with clay-colored stools, a corded pulse, nausea, vomiting and marked nausea. Lead-paralysis, a frequent variety of lead-poisoning has its homologue on the clinical side as has lead arthralgia, a painful condition of the joints. Lead encephalopathy which is characterized by headache, delirium, convulsions, coma, and death is a rare form of plumbism.

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## URINARY TUBERCULOSIS.

BY

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(Read before the American Institute of Homœopathy at Denver, Colorado.)

THE more or less definite views that have become current among the profession on the subject of urinary tuberculosis, have developed since Nitze created the art of cystoscopy, and Casper and Albarran and Nitze made the catheterization of the ureter feasible. My own systematic practice of cystoscopy and ureteral catheterization in connection with genito-urinary medicine and surgery dates from the year 1895. I believe this covers the earliest and hitherto longest period of systematic cystoscopic activity in the homeopathic school in America. While my practice, confined as it has been to private patients, cannot present a large array of cases of urinary tuberculosis, the cases that it can present were closely studied. The observations were unhampered by the divided, haphazard work of charity dispensaries and hospitals, and I have come to certain conclusions which I will now present for the sake of brevity, in a more or less axiomatic fashion, leaving to subsequent discussion any desirable amplification.

### I.

It must be admitted that urinary tuberculosis is not so common as pulmonary tuberculosis but it must also be admitted that, in both diagnostic and therapeutic aspects, urinary tu-



berculosis is much more complex. It is doubtful if it is ever primary, in the sense that there is no other tuberculous focus, cured or uncured, present in the system. First affecting the urinary glands through the circulatory blood, then following the course of the urinary flow and affecting the urine and finally affecting the tissues of the urinary reservoirs and passages. Urinary tuberculosis is of a hematic origin, and this means that we have to look elsewhere into extraordinary regions, for the primary focus where the tuberculous infection has entered and whence the tubercle bacilli have been disseminated. Many experiments have been made to prove the presence of ascending as well as descending forms of urinary tuberculosis. Yet, so far, nothing has been proved except that urinary tuberculosis has its beginning in the kidneys, but is often first suspected by the involvement of the bladder.

The painful manifestations in the bladder, however, are late occurrences of urinary tuberculosis. To know then, how the urinary tuberculous process manifests itself early in the kidneys, is of the first importance.

There are three forms of tuberculosis of the kidneys: The acute miliary form, the nephritic form and the chronic pyuric form.

In *acute miliary tuberculosis*, the tubercle bacilli are excreted through the infected glomeruli, pass through the glomeruli into the uriniferous tubules, where the bacilli multiply without first affecting the walls of the tubules, go down with the urinary flow except such as are caught in the straight tubules where they form Orth's excretory tuberculosis, finally affect the pelvis of the kidneys, the ureters, the bladder, but usually death occurs before much, if any, caseation or cavernization can take place.

In *tuberculous nephritis*, there is a distinct extraurinary focus of tuberculosis, usually pthisis, and with it an albuminuric interstitial or epithelial nephritis, the kidneys themselves free from specific tuberculous tissue, changes of caseation, cavernization, sclerosis. We must not confuse with this tuberculous nephritis, the mere urinary excretion of tubercle bacilli, and both tuberculous nephritis and *bacilluria* must be carefully distinguished from the true tubercular kidney which manifests itself by chronic renal changes of tuberculosis with pyuria and tubercle bacilli.

*In chronic renal tuberculosis*, we meet with all the stages of the tubercular process; the stage of tubercle without necrosis with caseation and cavernization and the stage of sclerosis surrounding the cavernous spaces.

The earliest stage of chronic renal tuberculosis, in any form, is glomerular. Chronic renal tuberculosis is, first, papillary. The cortex is normal, while the medulla becomes affected; then, while dissemination goes on in the pyramids, cysts appear containing urine from tubular closures towards the renal pelvis and the cortex begins to show infarcts of tubercles; then, beneath the cortex, caseous foci develop. Between the foci occur cavernous spaces that sometimes connect and sometimes do not connect with the renal pelvis.

The tuberculous kidney is most often a small kidney. It is not palpable. It is not painful. The patient very rarely complains of it, and most often complains of nothing until he has a cystitis.

In spite of this palpatorily negative phase of early renal tuberculosis, we must remember that there are certain changes in connection with the production of the urine that ought to at once call our attention to the possibility of the presence of a tuberculous process in the kidney.

## II.

The earliest discernible symptom of renal tuberculosis is, without question, *clear polyuria*. Turbid polyuria is a later symptom. Clear polyuria occurs long before there is any papillary erosion, with the characteristically sudden, apparently causeless, microscopic or macroscopic hematuria, long before tubercle bacilli appear in the urine and we have pus, *turbid polyuria*, characteristic polyuria.

With clear polyuria, there occurs early, *incontinence*. This is one of the earliest symptoms of a tubercular kidney and occurs not only in children but also in adults, and must not be confused with urinary incontinence, occurring as a late symptom of a rebellious contracted tuberculous bladder. The enuresis may be nocturnal, it may be diurnal, it may be both diurnal and nocturnal. If it occurs in a person under forty, not having had enuresis before, and not having any vesicle retention of which the enuresis may be the overflow, the com-

mencement of a renal tuberculosis ought to be suspected. Only within the last month, I had occasion again to verify this valuable observation in a case of renal tuberculosis, in consultation with Dr. Kingsley, of Woonsocket, R. I. The patient, a girl of nine, presented a history of enuresis dating from her second year, a history of cystitis at her third year, and a history of continuous uninterrupted enuresis ever since. Two sisters had also had enuresis. Theirs ceased with their fourth year. The patient's never ceased since it began.

For months, for a year, for even a longer time before we have tubercle bacilli and appreciable pus, we may have an *incipient* or what may well be known as a *light premonitory albuminuria* characteristic of the tubercular kidney. The albumen content is only one-fourth to one-twelfth pro mille. There are no casts. Only occasionally and then sparsely, there may be hyaline casts, but no other. If the albumin content is larger, one to two pro mille, and there are other than sparse hyaline casts, if hyaline casts are abundant and there are granular casts present, then the tuberculous albuminuria is complicated with a nephritic albuminuria.

My plea is to examine at once with the cystoscope every patient who presents clear polyuria, enuresis, light albuminuria, to catheterize the two ureters, test the secretion of the two kidneys separately, for only in this way can we ascertain or exclude at the earliest possible time, the existence, and control the process of renal tuberculosis, can we ascertain whether one kidney alone is affected and, if one kidney only is affected, which kidney it is that is affected. The solution of these important diagnostic problems is at the basis of the most effective modes of treatment that we may institute.

Without cystoscopy, we should still be where we were in the seventies of the last century, more or less helpless in the diagnosis of urinary tuberculosis, rudderless in the treatment of renal, ureteral and vesicle tuberculosis, and my plea today is for a much earlier and a more comprehensive cystoscopy with consecutive catheterization of the ureters than is currently practised. When the patient has turbid polyuria, the disease is already advanced beyond the early stage, and while cystoscopy with the concomitant and consecutive diagnostic measures is well indicated and will undoubtedly disclose clear-



er pictures of urinary tuberculosis, the result cannot be quite so welcome from a therapeutic standpoint.

We must not wait until we are able to palpate the kidneys or even the ureters. We must not wait until the bladder becomes painful, ulcerated, contracted. We must not wait until the urine is loaded with pus and tubercle bacilli. We must not wait until we are obliged to resort to Roentgenography, urethrotomy or pyelotomy for diagnosis.

It is a mistake to think that renal tuberculosis must have an abundance of pus and tubercle bacilli in the urine. Only when the kidney is cavernous will the urine be so purulent that it will deposit a thick creamy pus precipitate. *Pus* may be obtained in an early stage of renal tuberculosis when there are but isolated, small foci in the renal medulla. It is never absent from the urine if a tubercle connects with the excretory tubules, but the quantity may be so small as to be inappreciable in a twenty-four hour urine. If pus is taken from one kidney and not from the other, in ever so minute a quantity, though the pus be aseptic or rather *non-bacillary* or *non-bacterial*, we have unilateral infection.

In the earliest stages of chronic renal tuberculosis, the true tuberculous kidney, the *tubercle bacilli*, may be sparse or absent. The diagnostic injection of tuberculin, was therefore advised, to increase the bacillary content of the renal structures and the renal excretion, but I do not advise such a procedure; not merely because of the renal damage that a necessarily strong dose of tuberculin does to patients having renal tuberculosis, but because the kidney free from disease may react while the tuberculous kidney may not react. Bacilli may be obtained in the excretion of one kidney and pus, aseptic pus even, in that of the other kidney. There need be no mistake. The purulent kidney is the diseased kidney. Tubercle bacilli are more abundant after the early and before the later stages of renal tuberculosis. With a cavernous kidney, the bacilli are few in the urine taken from the kidneys while the bladder is full of bacilli. The reason for this apparent contradiction is the presence of bladder tuberculosis. Because of this condition there is also the usual persistence of tubercle bacilli in the urine of patients having been subjected to nephrectomy for a truly unilateral renal tuberculosis

and this persistence need give no anxiety for the other kidney if the bladder is properly treated.

*Guinea pig inoculation*, important as it is to prove the presence of bacilli in urine not otherwise demonstrable, does not of necessity prove the existence of renal or other urinary tissue tuberculosis. The urine may contain tubercle bacilli when the urinary organs are free from tuberculosis. We know the condition as bacilluria. The presence of pus is of much more importance for our diagnosis than the presence or absence of the tubercle bacilli. But, if with the pus, there is also blood, microscopic though it be, if pus and blood are constant, and we have tubercle bacilli, the diagnosis of renal tuberculosis is absolute.

In the absence of bacilli, pus in the urine of one kidney and a focus of tuberculosis in an extra-urinary region indicate tuberculosis of that kidney.

A kidney free from pus and normal in function may be considered free from tuberculosis even though it may transmit tubercle bacilli or show a light albuminuria. Such albuminuria may be accidental, due to catheter trauma, or may be a concurrent albuminuria of the healthy kidney, usual when the other kidney is tuberculous, or may be the interstitial or epithelial albuminuria of an otherwise inflamed kidney.

I have dwelt on the renal aspect of urinary tuberculosis purposely, because once we can exclude renal tuberculosis, we can localize subrenal tuberculous foci readily in the ureters, the bladder, the urinary passages also, because however many foci there may be below the kidneys, these foci are of secondary importance in the presence of a renal focus. *Clear urine with a normal degree of functional activity of a kidney* will exclude tuberculosis in that kidney.

### III.

We must test the functional activity of each kidney for three reasons: First, for the purpose of ascertaining whether the urine, clear or turbid, comes from a functionally normal or abnormal, efficient or deficient kidney. Second, for the purpose of deciding, by the degree of the renal efficiency, the extent of the tuberculous process within the diseased kidney. The kidney free from disease or less affected by it would be

able to continue to do the work theretofore done by both kidneys or do the work necessary for life.

It may be said that it makes hardly any difference what functional tests are used, the color test, or dilution test or sugar test or urea test or salt or freezing test. They are all good tests. What we must do however, is not to confine ourselves to any one test. In every instance we must use at least two different tests, one to control the other, in order to have the necessary certainty as to whether we are dealing with a healthy kidney or with a tuberculous kidney in an early or later stage of tuberculosis. For only he who has had to face the manifold problems that present themselves in the treatment of patients suffering from urinary tuberculosis, can appreciate what a responsibility there is to be met.

Shall we treat the patient medically or surgically?

Is urinary tuberculosis or extra urinary tuberculosis to be the point of attack for treatment?

Shall we use or not use tuberculin?

Shall we understand that operations for urinary tuberculosis are only palliative not curative?

Can incision and drainage or excision and closure result in the removal of urinary tuberculosis?

Shall we remove a kidney that is not badly diseased?

Shall we remove a badly diseased kidney when the other kidney is affected though less than the one to be removed?

Shall we resect a tuberculous focus of the only remaining kidney as Morris has done?

What shall we do and what shall we not do to make the days of the patient's suffering from bladder tuberculosis tolerable, not to speak of making them days of comfort, of peace and of happiness?

These questions assail us when we are brought face to face with the complete problems of urinary tuberculosis. To answer them with any degree of certainty we have to muster all the diagnostic skill of the genito-urinary specialist, all the therapeutic skill of medical men and surgeons, all the logical power that a training of the perceptive and associative faculties of the human mind can give.

I shall not attempt to answer these questions nor describe the technique involved. I shall only say in closing that, in my opinion, gained after an experience of nearly twenty-five



years and from a close study of the literature and the varied aspects of the subject of urinary tuberculosis, the best results may be hoped for in the early stage, when tuberculosis is confined to one kidney; that treatment with tuberculins and serums is no more efficacious, if at all, than with other medicines, that a mild, bland, fluid diet is better than the best climate; although a warm, dry climate is desirable; that in early renal tuberculosis before pus appears in appreciable quantities or when we may be in doubt whether tuberculosis is in actual development, a mild, bland, fluid diet and internal medication on the homeopathic basis of symptom similarity are to be preferred to any other known treatment. That antiseptic treatment is not indicated in renal tuberculosis, the tuberculous process not being a septic pyuric process; that nephrotomy is never indicated except in a tuberculous horse-shoe kidney, or in a bilateral renal tuberculosis, when retention of the pus causes high fever or when there is dangerous renal hematuria; that in unilateral renal tuberculosis, nephrectomy is indicated as soon as the tuberculous process has caused a decided functional diminution in the diseased kidney, no matter whether the patient himself feels well or whether the lower urinary passages are affected or not. That every delay of the operation or removal of the unilaterally diseased kidney proved to be tuberculous is dangerous; that a bad constitutional state referable to the unilateral renal tuberculosis is no contraindication; that, in bilateral renal tuberculosis, a nephrectomy is not advisable; that where both kidneys are diseased, retention of pus in one kidney, calls for a nephrotomy rather than a nephrectomy; that after a nephrectomy of the offending kidney, bladder tuberculosis may be cured and, when the offending kidney is not removed bladder tuberculosis may be greatly relieved if the offending kidney remains closed toward the bladder, but that, in the absence of an early nephrectomy or natural walling off of the tuberculous kidney, bladder tuberculosis remains to this very day, the bane of the genito-urinary specialist, in spite of the best bland fluid diet, proper internal medication, local instillations, palliative urethrostomy or nephrostomy.

**X-RAY IN THE TREATMENT OF TUBERCULOSIS.**

BY

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HELIO THERAPY, or the sun's rays, have played an important factor in the treatment of tuberculosis for ages. Now it is being brought more and more into vogue in the management of these cases. For ages all Europe has sent the "lunger" either to balmy, sunny Egypt and the regions of the Great Desert, or else to the Alps or Pyrenees, where elevation could be added to the sun's rays. In our own land, for many years the physician has sent his patients either to the Rocky Mountain plateau, or else to the balmy climes of California or Florida. In either place there is supposed to be greater amounts of sunshine than in less favored sections. Heliotherapy, or the exposing of the bare skin over the diseased area and parts of the entire body to the direct rays of the sun, is being used with great success in many places to-day. I want to commend this departure, or rather an attempt at intensifying the effect of the sun-rays, or getting the entire effect on the local areas.

Now, with X-ray this intensification can be done more readily and effectively with less exposure and danger to the patient than by any other method; and so I shall bring before you to-day what I have designated, "The method of intensifying natural elements in the treatment of tuberculosis until they become therapeutic agents."

I have found, in experimenting with X-ray in 1901-2, in the treatment of cancer, that great tissue changes took place, not only in the cancerous tissue but in the healthy tissues as well. This was more beautifully demonstrated in the treatment of breast cancer than elsewhere, for a small, shrivelled breast, where treated with X-ray, would become as large again as its fellow of the opposite side, due entirely to the hypertrophy and engorgement of the tissues. It was also noticed that the X-ray had quite an analgesic and anodyne effect. It was at this time considered that X-ray produced its effect on cancer cells by overstimulating them to the point of producing their death.

So, my first reasoning, after the accidental raying of a tuberculous mass in the abdomen, and noting the effect, was, that if tuberculosis was a disease of impaired nutrition or lessened blood-supply, why could not this agent be used to stimulate the tissues and increase the blood-supply and nutrition, and in so doing aid Nature to hasten fibrosis and repair the damage in tubercular conditions? Fortunately, the first few cases in which I used X-ray improved in such a remarkable manner as to completely enthrall me with the result, and many such results have come to me in the management of several hundred cases. My excuse for writing this paper is the hope that it will aid and stimulate other physicians to take up the work and help me develop and prove that in these agents we have a specific for tuberculosis. After I had been using these agents for some years it occurred to me that I was only using, in an intensified form, the natural elements that are paramount in the high and dry climatic resorts where patients are usually sent when a change of climate is desired, so I have styled the procedure as, "Intensifying Natural Elements Until They Become Therapeutic Agents."

Almost every X-ray operator can claim success in treating the various forms of tuberculous cervical adenitis, certain affections and tuberculous glands of the abdomen, etc., or, in other words, localized conditions. Pulmonary tuberculous conditions are not usually localized, but are constitutional or systemic conditions, and therefore more complex in their management; therefore I will devote myself entirely to pulmonary tuberculosis.

Probably the first thing in the treatment of pulmonary tuberculosis is for the physician to be familiar with the disease and know how to manage the patient so as to get the very best out of the hygienic, dietetic, and medicinal handling of the case. We know that Nature cures a great many cases of tuberculosis, even unaided, so intelligent help should cure many more; therefore, from a strictly hygienic standpoint, there is much to be looked after. I do not believe in the necessity or advisability of tent or sleeping porch, nor needless exposure to the elements. The sleeping porch and tent have been disastrous to me in my personal work, and with my method of treatment I can say unhesitatingly that we do not need them. Of fresh air we need an abundance—the purer the



better—but it has never cured a patient by itself, and thousands have contracted disease who lived in country homes (in the warm countries especially) where foul and vitiated air is unknown, so it is not necessary to jeopardize the life of your patient by trying to harden him to all kinds of weather. I would rather have a large room with four windows, one or two doors, and capable of being made comfortable when necessary, than any sleeping porch. The patient should be required to dress warmly and comfortably, and should be kept comfortable day and night. When confined to the bed the room should be kept scrupulously clean, the windows well opened, so the wind can blow through, and the room kept well ventilated—the room should never be kept hot. I always like a cold or cool room and let the patient use necessary cover and clothing to keep warm. I want a room that can be constantly flooded with sunshine, as sunlight is the great life-giving factor in tuberculosis, and poor indeed is the tubercular invalid who must be deprived of it. The feeble patient should not only be bathed daily but also sponged with alcohol.

*Diet.*—Few physicians and tubercular patients appreciate the importance of this heading. I sometimes think it is the axis around which the whole problem of success revolves. The physician who can have his patients eat the most and digest the best certainly has a great deal in his favor in the contest for success. I believe in a rich nitrogenous diet, based on meats, eggs, milk, bread and butter, etc.

*Medicines.*—In my method of work scarcely any medicines are used except to meet and palliate symptoms—and these are mostly remedies to aid digestion, support the heart and relieve the cough, etc. Pepsin, pancreatin, and the bitter tonics are used as needed to aid the stomach in digesting its full capacity three times at least daily; the bowels are managed so that each individual patient gets the greatest amount of nourishment from his food; the cough controlled by ether, morphine, codeine, heroin, or dionine, mostly the latter, unless there is danger of hemorrhage, or the cough is unusually severe. The X-ray has special virtues in this line, which we will discuss later.

*Heart.*—The heart requires much attention in this disease. In almost every case, even before a rise of temperature is

noted, the pulse is found weak and fast, and my own experience is that the blood-pressure is invariably below normal—so much so that very low and continued low blood-pressure should excite suspicion of tuberculosis. I think few cases of this disease will bear strychnine well and advantageously. Digitalis, ammonia, and most of the heart tonics can be used at some time with advantage. Electricity is of great service in supporting and strengthening this organ, and I use it continually for this purpose.

*Rest.*—This in many cases is an exceedingly important factor; frequently the physician must play dictator to have this factor carried out properly. I believe a laxity on this question has caused me more failures than anything else. In acute febrile cases it is imperative. It husband the patient's strength, aids his digestion, aids his nutrition, removes strain from the heart—all necessities for the recovery of the patient. A time comes, however, with every successful case, when exercise must be allowed. Here comes the danger. The better the patient feels, the stronger he appears, the greater danger of his doing some foolish thing that is liable to ruin him.

*Vaccines* may be used with some success, but in the majority of cases success is only temporary. Tuberculin, in properly-selected cases, may be used with undoubted benefit, probably in early cases, etc., but is of *no* use, and dangerous, in serious or fulminant cases. Neither of these agents is often needed in my method of work.

On the foundation briefly set forth we come to a description of the agents in our special method of procedure.

#### X-RAY—INTENSIFIED SUNLIGHT.

In the term X-ray are included five and one-half octaves of ether vibration, or, in other words, a range of vibratory rays more than five times as broad as those that are seen or comprehended by the human eye. When you think of each of these five octaves having qualities all their own you can begin to grasp somewhat the different therapeutic possibilities there are in the term X-ray. Sunlight is the greatest foe to tuberculosis in the physical and organic world as well, so I have come to the conclusion that this light, inten-

sified millions of times as we have it in the X-ray, is the greatest foe to the germ of tuberculosis in organized tissue we possess to-day.

When I first began to use X-ray in treating pulmonary tuberculosis my idea was to give just enough X-ray to produce a hyperaemia of the diseased lung tissue, and thus, by the increased blood-supply and the nourishment to the tissues, combined probably with an inhibitory effect on the development and well-being of bacilli, to help the tissues fight a winning fight with the disease. Now to this reaction and engorgement we claim there takes place a decided inhibition in the development of the bacilli: some are so weakened that death soon takes place, while others probably die from the direct effect of the rays, but probably others are attenuated and their virility destroyed, giving us a harmless germ, similar to Webb's attenuated bacilli, or the turtle or cold blooded animal bacilli. Anyway, when this result or combination reaches the blood, and then lymph streams through the body for removal, it is immediately attacked by the leucocytes, probably by the large mononuclear mostly, but in the process of liquefying and digesting these bacilli by the leucocytes their toxins are eliminated or brought in contact with the blood stream, and Nature must necessarily furnish amboceptors or antitoxin to neutralize these toxins, or the patient will rapidly succumb. This process, I claim, gives us the finest imaginable autogenous vaccine for our cases. McCullough, of London, and Crane, of Michigan, both claim to have been able to prove that by means of X-ray a constant positive phase of the opsonic index can be maintained in tuberculosis, which is the most favorable condition possible, according to Wright and Douglas. Another effect of the X-ray which I have not heretofore cited is what we will call the squeezing or contracting effect. This is illustrated in the treating of tubercular glands or in large carbuncles. It is possible, in these cases, in fifteen minutes, to squeeze or contract these tissues to almost half their size—at least, reduce them perceptibly almost at once. These cases go on to a cure. Can we by this contracting power of the X-ray force these bacilli out of their hiding places, directly into the circulation, or somewhere where they can be reached by the leucocytes and



destroyed? In the squeezing-out process, are these bacilli so weakened and vitiated by the ray as to make them especially easy of destruction by leucocytes? As we have never noticed any untoward effect from the X-ray under these conditions, this would be in keeping with much favorable experimenting that is being done now with the vaccines or serums containing the living attenuated germ.

In closing this fascinating subject I will say to our bacteriologic friends that to make their vaccines and serums a complete success there is an element they need and have not found. I say, with X-ray in tuberculosis, also in healthy tissue, blood, and spleen, we have found an element which we do not thoroughly understand, and hide our ignorance under the name of toxin and antitoxin, and it is this element I consider the capstone in the arch of a specific for tuberculosis, whether it is produced by the X-ray, or whether finally wrung from the bacteriologic laboratory. It must be remembered in all X-ray treatment that the idea is to produce a reaction in the diseased tissue and also in the adjacent normal tissue, and the dosage to obtain this reaction is the *real* secret of all X-ray treatment.

#### ELECTRICITY.

This I consider the most important auxiliary to X-ray in the treatment of tuberculosis. The method I prefer is the Brush discharge from the static machine. This is what I like best ordinarily, but other forms will have to be substituted occasionally; but as a routine measure I prefer the Brush discharge, given under the upper spine and shoulders, paying especial attention to the sites of old and other pleurisies. An effort should be made to relieve all pain, if any exists, at such treatment. I have reached the conclusion that more beneficial results can be obtained in stimulating the stomach to increased action from electricity than from any other agent. The effect of the Brush discharge is especially useful in the heart conditions of those patients. I find that my patients stand the X-ray better and the skin is less affected by the rays when I use the Brush discharge, so, saying nothing about the metabolic effect, the soporific, the eliminative, and anodyne effects, we are bound to admit that it has attributes which force the recognition of its value in

these cases. It is one of the attributes of a dry climate like Colorado, and with a static machine can be intensified to any point. I usually use it every other day, alternating with the X-ray. It is usually used for about ten minutes at each seance, or until the palms of the hands become moist, as a routine procedure.

#### OZONE.

This measure has been most extolled in the treatment of tuberculosis for many years. I think it is of undoubted value—less, perhaps, however, than either of the other agents, but useful, nevertheless. I use it, passing it through a nebula of menthol, camphor, eucalyptus oil, pine-needle oil, and argyrol and liquid petroleum. This mixture is nebulized through a compressed-air machine and forced through the ozone generator, where it mixes with the ozone in the proportion of one to three atomic weight without any chemical changes, thus giving an ozonized nebula, which is inhaled by the patient with moderately deep breathing every day. The only care required is to watch for bronchial spasms.

#### TECHNIQUE OF ADMINISTERING X-RAY.

X-ray is usually given three times weekly, on alternate days with static electricity. We want the ray generated by a machine that is capable of furnishing the ray with good volume of output, not altogether rays as swift as the late-day skiagraphic ray, but a ray that will take the skiagraph of the ordinary tubercular lung in from one to two minutes with about one or two milliamperes flowing through a large tube for some ten minutes, the tube being within 14 to 18 inches of the patient's chest (owing to the perfection of the ray used). The patient is treated one day in front of the chest, the next time over the back of the chest. Care must always be taken to watch effects of the ray on the skin, and the distance of the tube regulated accordingly; of course, the patient's head, face, and genital regions must be covered with lead or other protective agents. Remember that we are treating for the express purpose of bringing about specific reactions, but that we want them in the lung and deep tissues of the body, not in the skin. The usefulness of the X-ray

depends entirely upon the correct dosage with which it is given, and herein lies the whole secret of the success of the treatment: if your dose is too small, you do no good; if your dose is too large, you do harm in different ways, throwing too much debris into the circulation, injuring the kidneys, producing toxaemia, endangering the skin, and making your patient miserable. But, to be effective, the reaction must be maintained, as it is the reaction of the tissues, normal and pathological, respectively, through the X-ray, which produces the cure or beneficial effects—and therefore the ideal should be to use the X-ray in such a manner as to try and keep the opsonic index in a continual positive phase. This is the difficult part of the work; it will vary with different patients on account of their respective resistences; the type and kind of machine giving the value to the ray will vary, so each individual case will have to be watched and treated according to its own requirement. I consider the X-ray as having attributes of special advantages of its own in the treatment of pulmonary tuberculosis, for:

*First.*—It prepares, you might say, a field on which to fight the battle with the germs. It does this by drawing large quantities of blood and nutriment to the diseased parts, by virtue of its own irritating and stimulating properties; thus the hyperaemia, and engorged tissues are more able to cope with the bacilli, living or dead.

*Second.*—There is nothing else of a remedial nature that can enter the enclosed or encapsulated tubercle and destroy or inhibit the multiplying of the bacilli in the encapsulated tubercle like X-ray. The blood-supply is cut off; does not reach inside of the encapsulated or enclosed tubercle, so how can any blood-carried specific or serum have any effect on this class of tubercle? X-ray penetrates these tubercles encapsulated, enclosed or otherwise, just as it penetrates bones, and with its death-dealing power inhibiting propagation of the bacilli, weakens and finally destroys them. This effect on the tubercles I consider one of the most important effects of the X-ray in this disease, as it lessens the chances of new invasions of the bacilli in the future, and therefore the patient is more free from relapses. This enables me to claim that a patient with sufficient X-ray should never die of tuberculosis.



*Third.*—In previous papers I have intimated that the X-ray should probably be laid aside for tuberculin in incipient cases of pulmonary tuberculosis. I wish to rectify this statement, as we find that from 65 to 70 per cent. of all pulmonary tuberculosis originates first from infections of the bronchial and mediastinal glands, and spreads from them usually first to the apices, and then, fan-like, over the upper lobe of the lungs. When we remember how effective X-ray has proven in tubercular cervical adenitis, why should it not be equally effective in the bronchial glands and thus abort the pulmonary tuberculosis, which I believe can be done, and will be really the great prophylactic measure of the age? I am convinced that in this class of cases Von Ruck vaccine is of greatest value and I believe an examination will give us perfect results.

*Fourth.*—The prophylactic effect of treating these glands with X-rays is of transcendent importance. How can we expect to cure a case of pulmonary tuberculosis, and have it remain cured, when the original foci of infection is left behind? So long as these glands harbor bacilli, will they not continue to put them into the lungs? Is this not the great cause of recurrent attacks? Every Rontgen operator claims X-ray can cure and will cure tubercular glands; then why should it not be used on bronchial glands, by all means, even incipient, doubtful, or suspicious cases?

I will briefly summarize the effects of X-ray as I find them to occur in the treatment of pulmonary tuberculosis.

*First.*—An engorgement or hyperaemia of the lungs.

*Second.*—The number or quantity of rales is temporarily increased.

*Third.*—The cough is ameliorated by loosening and liquefying the sputum, making it easier of ejection.

*Fourth.*—Aids the gradual reduction of temperature.

*Fifth.*—Relieves pleuritic and muscular pains and soreness of chest.

*Sixth.*—Improvement of the well-being of the patient, as shown by gain in weight, slowness of pulse, improvement in digestion, etc.

*Seventh.*—Shortness of breath will be increased in advanced cases, due either to the toxin or to the pulmonary congestion.

*Eighth.*—During the third month of treatment ordinarily there will appear, in advanced cases, white flecks of sputum mixed with yellow. The white increases and the yellow decreases until the white supersedes the yellow entirely.

*Ninth.*—Usually during the third month in ordinary cases the rales begin to disappear, and I count on the lungs being clear by the end of the fourth month.

*Tenth.*—The X-ray has more influence on the second—and third—stage cases than on incipient cases of very slight involvement. The reason of this is that autogenous vaccines are readily produced by the rays where there are large areas of germ-infected tissues to contend with, while in the slight, incipient cases it is difficult to make a vaccine, and one must depend upon mechanical effects entirely, which can probably be aided by tuberculin.

*Eleventh.*—Any case that has vitality sufficient to react to the influence of the rays and furnish amboceptors or antitoxins, thus completing the vaccine formation in the blood and tissues, is susceptible to improvement by the use of the rays, with proper dosage, nursing, food, and care. I have seen more than one patient almost raised from the dead.

*Twelfth.*—It is not dependent upon circulation, but penetrates all tissues, bones, muscles, etc. It also penetrates the tubercles, old and young, with its inhibiting effect on bacilli—something that can be accomplished by no other agent.

*Thirteenth.*—X-ray is only intensified sunlight, and you can put more light through the lung in ten minutes with the X-ray than you will get in a month of sunshine.

These are some of the conclusions I have reached from observing something over four hundred cases, forty-six of whom are dead from various causes; the balance are alive at this time, and the vast majority of them are bread-winners. By far the larger percentage were advanced second—and third—stage cases. At the present time many of these cases do not react to tuberculin, nor can bacilli be found in their sputum. The great trouble I find in getting an absolute, and you might say perfect, cure is that the majority of the patients, when they get well enough to work, having been idle so long, *will* return to business; they consider themselves well, and cannot be prevailed upon to continue treatment until perfect results are obtained. The vast majority of the patients, af-

ter being dismissed completely and returning to work, have returned to their homes in the East, North and South. Three of these have returned for treatment, one of whom died; the other two are back at their homes and at work to-day.

In closing this paper I want to emphasize the fact that the patients who recover from this method do *not* relapse or have a reinfection to anything like the extent of patients treated simply by climatic, hygienic, and dietetic methods.

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## Transactions of the Homoeopathic Medical Society of the State of Pennsylvania.

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### BUREAU OF HOMOEOPATHIC INSTITUTES AND CLINICAL MEDICINE

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#### A CONSIDERATION OF THE DIAGNOSIS OF EARLY AND OBSCURE CASES OF PULMONARY TUBERCULOSIS.

BY

G. HARLAN WELLS, M. D., PHILADELPHIA.

GENERAL medical practitioners have recently been strongly condemned by specialists and by the laity for the frequency with which they fail to recognize the existence of pulmonary tuberculosis in its early and obscure forms. For example, one writer in a popular magazine, recently stated that the greatest obstacle to the eradication of this disease was the ignorance of doctors. This condemnation of medical practitioners is based upon the following observations:

First: While the average case of chronic pulmonary tuberculosis lasts ten years or more, statistics show that it is ordinarily diagnosed by the medical man in the last year or two of its course.

Second: Of the cases presented for admission to the tuberculosis sanatoria, sixty per cent. are incorrectly diagnosed.

Third: While investigation shows that the doctor with an average general practice has about twenty cases of tuberculosis among his clientele all the time, but one out of ten are reported to the Boards of Health where compulsory reg-



istration of cases of tuberculosis is required, and ninety per cent. of those reported are far past the incipient stage of the disease.

Now, while these statements are, in the main, correct, they *do not prove* what the majority of the critics would have us believe, namely—that the average general practitioner is either grossly stupid or criminally negligent. In my opinion they *do prove that the diagnosis of incipient or obscure pulmonary tuberculosis is a difficult matter* and, to be expert in such diagnosis, requires long training and daily experience. I do not hesitate to state that it requires more experience and more mental acumen to correctly diagnose early and difficult cases of pulmonary tuberculosis, than to perform an ordinary abdominal operation.

Did time permit, I could bring to your attention a number of facts to substantiate these views but I shall content myself with mentioning but three:

First: I have seen a number of cases pronounced free from pulmonary tuberculosis after examination by some of the most noted experts on physical diagnosis, die within twelve or sixteen months of this disease.

Second: The records of all of the large insurance companies show that thirty-five per cent. of the mortality rate from tuberculosis occurs during the first three years of insurance and fifty-three per cent. of the mortality rate occurs during the first five years of insurance. It is probable that practically all of the fifty-three per cent. were infected with the disease prior to the time the expert examiners of the companies passed them as being in perfect health. The inability of the examiners to recognize this disease cost one insurance company nine millions of dollars in six years and Green is responsible for the statement that it cost the insurance companies of New York State alone fifty millions of dollars during the same period of time.

Third: An investigation of the cases of tuberculosis occurring in the army and navy shows that the vast majority of cases develop during the first two years of enlistment, proving beyond a doubt that the disease already existed among the applicants at the time that they were passed upon by the medical examiners as being free from such infection.

These facts show that it is an extremely difficult, even for

men especially trained in the art of physical examination, to recognize early and obscure cases of pulmonary tuberculosis, and we should not, in fairness, be too ready to condemn the general practitioner if he commits the same error. *The point I would like to urge upon the general practitioner in this connection is that, he should be ever on the alert to suspect the presence of this disease, and when suspicious symptoms are present, to insist that every possible effort should be made to determine definitely whether the patient is tuberculous or not.*

In the investigation of cases of suspected pulmonary tuberculosis according to modern methods, we can obtain valuable information from five sources:

First: The Clinical History.

Second: The Physical Examination.

Third: The Radiographic Examination.

Fourth: Examination of the Sputum.

Fifth: The Tuberculin Tests.

#### THE CLINICAL HISTORY.

The first point of importance in the clinical history is the question of exposure of the individual to tuberculous infection. If we find that one or more members of the patient's family have suffered from tuberculosis, it is important to ask whether or not our patient was associated with the infected person during his illness. We should also particularly inquire whether our patient was intimately associated with tuberculous individuals not members of his family. The fact of association with a tuberculous individual is, in my opinion, vastly more important than the relationship existing between them. In other words, if we find our patient has been intimately associated with a tuberculous individual during the last year or two of that individual's life, the probability of infection is very great, no matter whether or not any blood relationship existed between the two individuals. As to direct heredity, it is my personal opinion that it is of little importance. The contraction of tuberculosis is a matter of association and not of hereditary transmission.

It is often well to inquire whether our patient has lived in a house in which a number of tuberculous people have died. Tuberculosis is largely a house disease, and infection may

take place as a result of living in a room previously inhabited by tuberculous individuals.

We should next particularly inquire whether during his childhood our patient suffered from cervical adenitis or any manifestation of so-called scrofula. A history of pulmonary hemorrhage at any time during the past may also be of diagnostic value.

We are now ready to inquire as to the present state of our patient's health and, it is important to remember in this connection, that *patients suffering from incipient pulmonary tuberculosis may present few or no symptoms*. If we are able to disabuse our minds of the idea that all persons infected with tuberculosis must necessarily run a fever, accompanied by profuse night sweats and a severe cough with expectoration of blood or cheesy masses, we have made a great step toward reaching a proper view point for the correct diagnosis of this disease. Tuberculosis in its early stage is probably the mildest of all chronic bacterial infections and its existence is not at all incompatible with comparatively good health.

The onset of the disease may at times be apparently acute but in the vast majority of cases it is gradual. The symptom most commonly present during the early stage of infection is a feeling of lassitude or languor, especially worse in the afternoon or evening. The patient complains of being unusually tired and is easily worn out. Accompanying this lassitude, we find in ninety per cent. of the cases, some form of gastric disturbance. This may take the form of simple anorexia or of some type of dyspepsia. Nausea with a tendency to vomit on slight provocation is not infrequently present. Cough may or may not be present, and when present it is usually slight and attributed to a catarrhal condition of the pharynx, which ordinarily exists in this class of cases.

The following table shows the relative frequency of the various symptoms in the incipient stage of tuberculosis:

Lassitude 98 per cent.

Gastric disturbance 90 per cent.

Hemaptosis 26 per cent.

Pleurisy 46 per cent.

Liability to colds 38 per cent.

"Influenza" 51 per cent.

Accompanying the above mentioned symptoms we are able



to discover by careful observation, in the majority of cases, that the patient has a slight daily rise of temperature. This febrile rise is usually present in the afternoon or evening and rarely exceeds  $99.5^{\circ}$  or  $100^{\circ}$ . The patient is often unaware of the existence of this fever and it will only be discovered by daily observation with the clinical thermometer. A slightly rapid pulse of low tension is present in more than fifty per cent of the incipient cases.

As the disease progresses, the conditions above referred to gradually become more marked: the debility increases, the patient begins to lose slowly in weight, the stomach becomes more easily disturbed and the cough and bronchial symptoms become quite manifest. After a period of many months or even years, secondary infection by pyogenic organisms takes place, and the well-known symptoms of "consumption" develop, namely— hectic fever, night sweats, emaciation, cough with expectoration of cheesy masses, etc.

#### THE PHYSICAL EXAMINATION.

In the very early stage of pulmonary tuberculosis, a *physical examination usually fails to reveal any abnormal diagnostic signs*. The investigations of Ruata and of Galbraith show that the average period that elapses from the time of infection to the onset of definite physical signs, is from two to four years. Even at the end of that period, inspection, palpation and percussion usually give negative results and the first signs to appear can be elicited only by auscultation. The most characteristic sign that can be discovered by auscultation in the incipient stage is the presence of localized moist rales in the apex of a lobe. These rales are usually fine, crackling sounds heard on deep inspiration, and it is often necessary to have the patient cough in order that they may be detected. When persistently present in the location above referred to, they are strongly indicative of the existence of tuberculous infection. Other auscultatory signs of importance are: (a) harsh breathing with a prolonged high pitched expiratory murmur; (b) diminished respiratory murmur, (c) cog-wheel breathing. All these signs are of particular value if found over a localized area, especially if this area is situated in the apex of a lobe.

With the progress of the disease, auscultatory signs become more manifest and after a time we are able to detect changes in the percussion note. Impairment of percussion resonance usually manifests itself first either posteriorly above the scapulae or anteriorly below the clavicles on either side. Careful percussion of the apices of the lungs, with a view of determining the relative breath and resonance of the apices, is a valuable diagnostic procedure. Unilateral contraction of an apex is more commonly due to tuberculosis than to any other disease.

The various types of chests which the textbooks describe in detail as predisposing to tuberculosis, are in the main, traditional misconceptions that have been handed down for centuries. Tuberculosis may develop in a chest of any shape or size and most of the textbook descriptions portray to us types of chests in which the disease has existed for a long period of time. Such data is of very little importance in early diagnosis.

As the disease passes into the second stage, increased vocal fremitus, decided dullness on percussion and moist or bubbling rales with broncho-vesicular and even bronchial breathing, are detected. As the present paper deals chiefly with the diagnosis of early cases, I will not go into further details in regard to the well-known physical signs of the second stage.

#### THE RADIOGRAPHIC EXAMINATION.

The development of the high-powered interrupterless transformers for radiographic work has furnished us with a valuable method of diagnosis in suspected cases of pulmonary tuberculosis. During the past year I have radiographed practically all cases suspected of being tuberculous and am convinced that it is possible in the large majority of cases to make an accurate diagnosis of this disease by means of a radiographic picture, considered in conjunction with the clinical history, two to three years before physical signs of definite diagnostic value can be demonstrated. Physicians who base their ideas of the value of an X-ray examination on plates made with the old fashioned coils requiring from five to twenty seconds exposure, will, no doubt, be inclined to question the truth of this statement. Such radiographs, however, are not to be compared with those obtainable by a



PLATE I. NORMAL CHEST.

Note shadow of the heart and just above it, on either side, the shadows cast by the roots of the lungs (hilus shadow). Other portions of the lung uniformly clear on both sides.

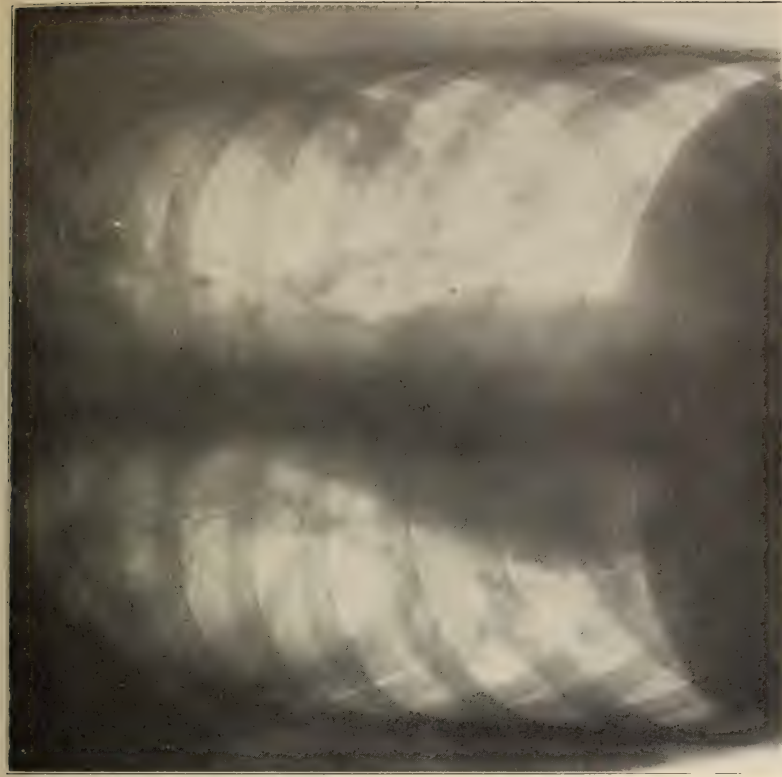


PLATE II. TUBERCULOUS INFILTRATION OF BOTH APICES.

Note the shadow extending from the hilus of the lung upward, expanding to fill the apices



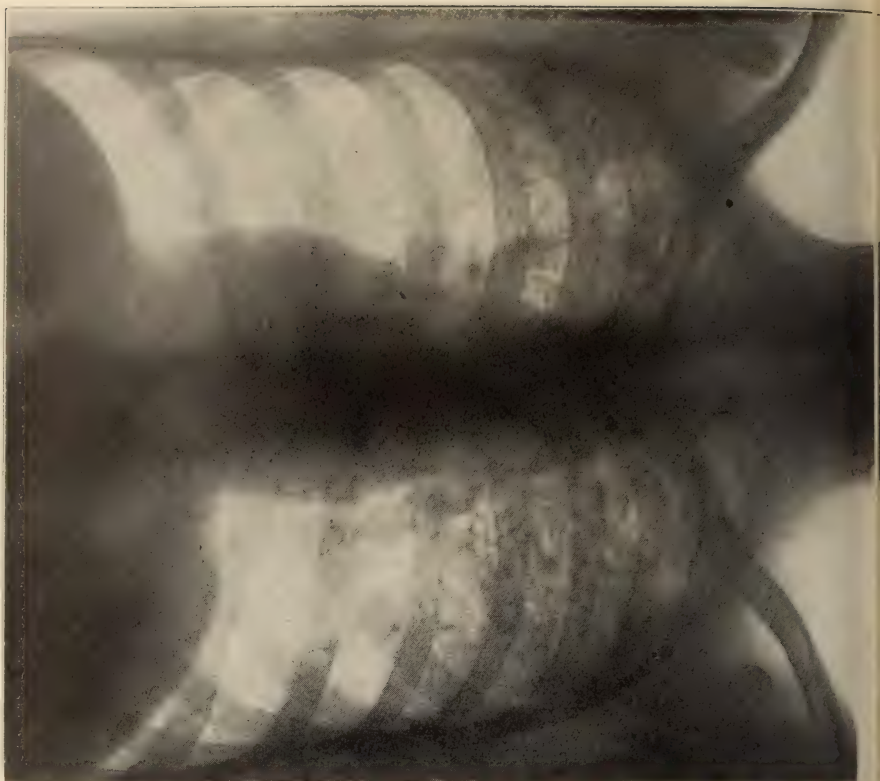


PLATE III. TUBERCULOUS INFILTRATION OF THE RIGHT LUNG BELOW THE CLAVICLE.  
Note the circular infiltrated area extending from the hilus shadow outward toward the axillary region.

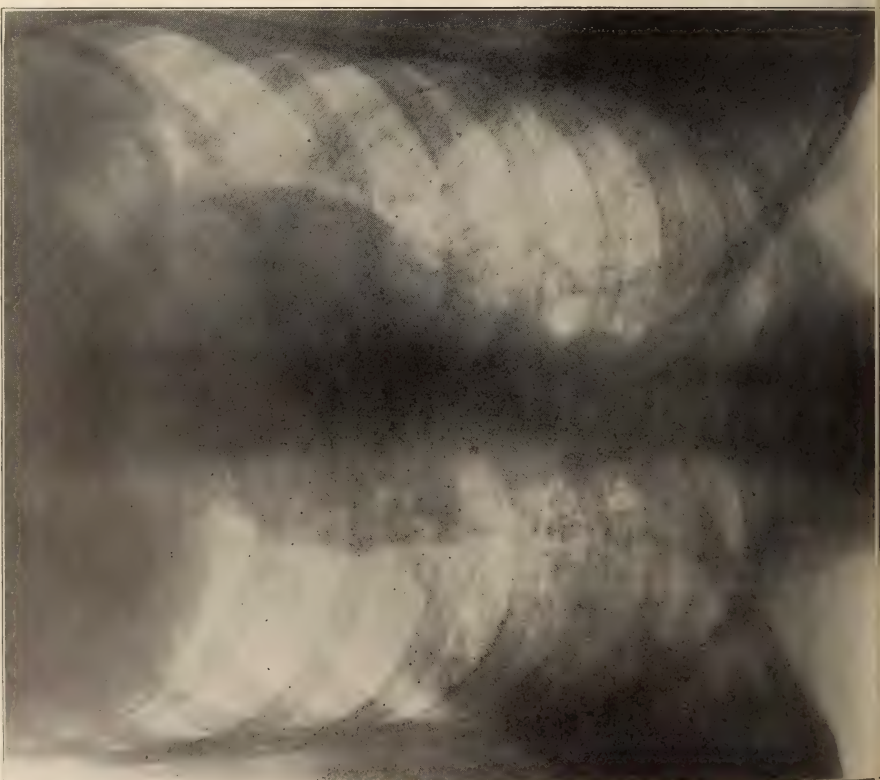


PLATE IV.—TUBERCULOUS INFILTRATION OF THE UPPER HALF OF BOTH LUNGS.

high powered transformer, capable of making a radiograph in one-half of one second or even in a tenth of a second if necessary. In making the radiographic pictures used in illustrating the present article, I employed a twelve K. W. interrupterless transformer and in no case did the exposure exceed one second in time.

The diagnosis of incipient pulmonary tuberculosis by modern radiographic methods depends chiefly upon the demonstration and interpretation of:

- (a) The hilus shadow.
- (b) Areas of localized vascular congestion.
- (c) Thickening and adhesions of the pleura.
- (d) Limitation of the movements of the diaphragm.

The hilus shadow is cast by the root of the lungs and its density is due to the presence of the bronchi, the blood vessels and the lymphatic structures as they enter the lung at this point.

Tuberculous infection produces changes in the hilus shadow in a very large proportion of cases. These changes consist in an increase in the area of the hilus shadow, in alterations in its consistency and in localized condensations.

Isolated areas of vesicular congestion constitute a radiographic finding of great diagnostic value in suspected cases of pulmonary tuberculosis. These areas of congestion give rise to a cloudy or mottled appearance in the apex or in other portions of the lung. Though often isolated, these areas may be connected with the hilus shadow by a cloud-like film due to thickening and congestion of the blood vessels passing from the root of the lung to the affected area.

Localized thickenings of the pleura and limitation of the movement of the diaphragm are both suspicious but not conclusive diagnostic evidence of tuberculous disease.

Plate I: This is a radiograph of a normal lung and should be studied carefully in order to fix in one's mind the normal appearance of the hilus shadow, of the heart and of the pulmonary structures. The hilus shadow can be distinguished as a faint cloudiness extending parallel to the vertebral column on either side, beginning (in this plate) three-fourths of an inch below the inner edge of the clavicle and extending downward for a distance of about one inch. It is larger and more clearly defined on the right side than on the left. The heart

can be seen as a dark shadow near the center of the thorax, resting on the diaphragm below and extending chiefly to the left of the vertebral column. Note the clear pulmonary tissue shown in the right and in left side of the thorax. It will be seen that the apices of the lungs are clear and present the same appearance on both sides. In the original negative the the minute divisions of the bronchi can be traced readily from the hilus shadow outward to the periphery of the lung, but it has not been found possible to satisfactorily reproduce this in the half-tone illustration.

Plate II: This plate illustrates a common finding in an early case, namely, an area of increased density extending from the hilus shadow upwards on both sides of the chest to fill, more or less completely, both apices. Clinically, this patient gave a history of lassitude, loss of appetite, a slight loss in weight with susceptibility to attacks of bronchitis. His temperature never rose above 98.3°. The physical examination showed no impairment of the percussion note and no definite signs on auscultation. The radiograph shows quite clearly the rather diffuse tuberculous infiltration in both apices.

Plate III: This plate is of special interest because it shows how a quite extensive infiltration of the lung may escape detection by the ordinary methods of physical examination. The patient, a young man, twenty-one years of age, a brakeman by occupation, considered himself in perfect health until he suddenly had an attack of hemoptysis, at which time he raised about eight ounces of blood. He was put to bed and the bleeding was soon controlled. His physician made a careful examination of the chest with negative results. I saw the patient about ten days after the hemorrhage occurred and, after a very careful examination of the chest, was able to find no abnormal physical signs. I then took a radiographic picture of the chest, demonstrating as will be seen in the plate, a rather diffuse lesion in the right side of the chest extending from the clavicle downward toward the axilla.

This patient was referred to a well-known tuberculosis sanatorium and at the examination made prior to admission the tuberculosis experts who went over him, failed absolutely to locate the pulmonary lesion.

Plate IV: Represents an advanced case of pulmonary in-





PLATE V.—TUBERCULOSIS OF SEVERAL YEARS DURATION.

Note the complete consolidation of the left lung with contraction of the left side of the Chest.

volvement. This patient presented numerous clinical symptoms and well developed physical signs. As will be seen in the illustration the upper half of both the right and the left lung is consolidated.

Plate V: Illustrates a case of tuberculosis of several years standing. The practically complete consolidation of the left lung with marked contraction of the thorax on that side and the compensatory emphysema of the right lung, are readily made out.

Did space permit, dozens of plates might be shown illus-

trating various degrees of tuberculous infiltration, but I have selected these few as types of certain important normal and abnormal conditions.

While the above remarks have applied mainly to the diagnostic value of the X-rays in early cases, it should also be borne in mind that a radiograph is of considerable value even in cases readily diagnosed by physical signs, because of the fact that it gives us an accurate and permanent record of the extent of the tuberculous process and is of great service in making future comparisons as to the progress of the case.

The radiographic study of cases of pulmonary tuberculosis has also led me to believe that the view commonly held by clinicians and pathologists, namely, that tuberculosis usually begins in the apex of a lobe, is incorrect. The large proportion of early cases showing alterations in the hilus shadow prior to the development of areas of peripheral congestion, has convinced me that the true seat of early infection in the majority of cases is in the lymphatic structures at the root of the lungs. From this point the process progresses to the apex or some other peripheral portion of the lung and it is there that the clinician is first able to demonstrate definite physical signs.

In closing my remarks on the value of the radiographic examination, I wish to state that the interpretation of the radiograph is quite as difficult a matter as its production, and unless the diagnostician is thoroughly familiar with the pathology and clinical course of tuberculosis and with the details of the history of the individual case under consideration, as well as with the technical significance of the various lights and shadows that appear on the radiographic plates, he cannot hope to arrive at satisfactory conclusions in any large percentage of cases.

#### THE EXAMINATION OF THE SPUTUM.

We are able to identify the tubercle bacillus in the sputum of only a very small percentage of cases of early pulmonary tuberculosis (14 per cent). Repeated examinations of the sputum by the anti-formin method has slightly increased the percentage of positive findings. It must not be supposed however that because we are able to find the specific micro-or-

ganism in but a small percentage of cases that the examination of the sputum is unimportant. In a very few instances the finding of the tubercle bacillus in the sputum is the first evidence of the disease that we are able to obtain and, in all cases it should be carefully searched for, as the persistent presence of this organism in the sputum constitutes the most positive evidence we can obtain of the existence of tuberculosis. In the more advanced cases the bacillus can be identified in an increasing number of cases, and it is probable that some time prior to death it can be identified in practically all instances.

#### THE TUBERCULIN TESTS.

There are three methods of applying tuberculin in the diagnosis of pulmonary tuberculosis, namely, the ophthalmic test, the cutaneous or von Pirquet test and the subcutaneous test.

The ophthalmic test is mentioned merely to warn the general practitioner against its use. Many serious inflammatory conditions have developed in the eye following this test and the information furnished by its use is far from reliable.

The cutaneous or von Pirquet test is readily carried out and is free from danger. The technique consists in cleansing the skin of the forearm with ether and then by means of a scalpel or small scarifier, scratching the skin on the inner side of the forearm, until the lymph spaces are opened up, in three small areas about one inch apart. One drop of Koch's "old" tuberculin is then placed on two of these areas and the third is allowed to remain uninoculated as a control. The development of a hyperemic macule and papule within twenty-four to seventy-six hours around the inoculated areas, the control spot remaining normal, constitutes a positive reaction.

The von Pirquet test has positive diagnostic value in children from one to three years of age. After three years of age its value diminishes rapidly and *in adults it is of very little importance*, being present in ninety per cent. of all persons over ten or twelve years of age. The disadvantage of this test arises from the fact that a reaction occurs in the presence of anatomical as well as of clinical tuberculosis and, therefore, it is of little help in determining the presence or absence of an active tuberculous process.



The subcutaneous injection of tuberculin is by far the most accurate and positive method of using tuberculin for the diagnosis of active tuberculosis in adults. When properly performed it gives positive and definite information as to the presence or absence of clinical tuberculosis, and if its indications and

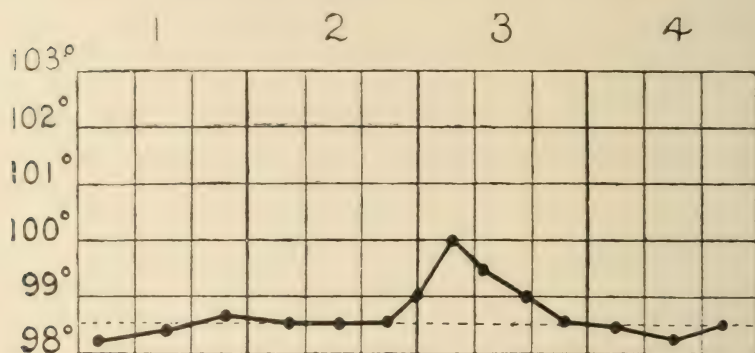


PLATE VI.—REACTION FOLLOWING INJECTION OF .001 C.C. OF TUBERCULIN.

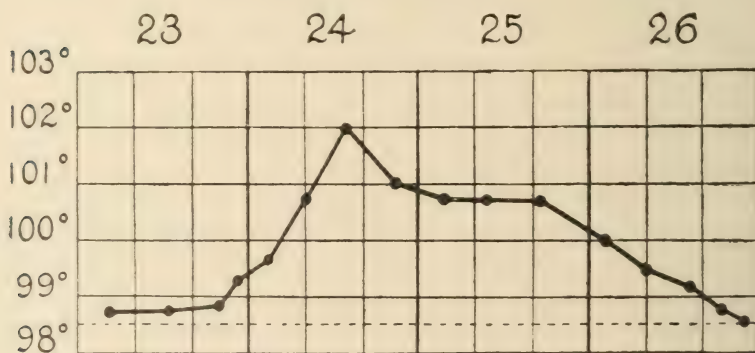


PLATE VII.—REACTION FOLLOWING INJECTION OF .005 C.C. OF TUBERCULIN.

contra-indications are understood and observed, it is entirely free from danger. After having given some several hundred injections of tuberculin I have yet to see a single case in which any harmful results followed. *It is indicated as a diagnostic agent in those cases in which a careful study of the clinical history and a thorough physical and bacteriological examination fail to furnish data sufficient to reach a definite conclusion.* It is contra-indicated in all cases whose maximum daily temperature observed over a period of one week exceeds  $100^{\circ}$ ; in cases with rapidly developing or with widely disseminated

tuberculous changes. *It is not to be regarded as a short cut to diagnosis but as a method of last resort*, when the measures previously referred to fail to give us satisfactory information.

I have described the technique of this test in previous articles and will content myself with stating briefly at this time, that the test is carried out by injecting subcutaneously .001 c. c. of Koch's "old" tuberculin. If the patient is clinically tuberculous, this injection will be followed within twenty-four to forty-eight hours by a rise of temperature of one degree or more, which febrile rise is accompanied by more or less general lassitude. If no reaction results within three days .002 c. c. of tuberculin are injected and, if this fails to produce a reaction, .005 c.c. are given. If the patient fails to react to this latter dose, he can be considered free from clinical tuberculosis.

The two conditions that may give rise to a similar reaction are the secondary stage of syphilis and leprosy. Leprosy is so rare in the United States that we can practically disregard it. Secondary syphilis can usually be differentiated by a history of the case and by the presence of the characteristic skin lesions of that disease.

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### PERIPHERAL IRRITATION IN GIRLS.

BY

MARY E. COFFIN, M. D., PITTSBURGH.

INSANITY is on the increase; nervous disorders are demanding more careful investigation; morbid introspection, hysteria and many psychopathic states are so common as to cause serious concern for the mental poise and stamina of our nation, for "the hand that rocks the cradle is the hand that rules the world," and the girls of to-day are most certainly the mothers of to-morrow.

Therefore, in this age of strenuous living and close competition, when every atom of nervous and physical energy is needed in order to attain success, anything which weakens or wastes this energy deserves careful attention.

Heredity tendencies, home surroundings, education (or the

lack of it), food, companions,—so many factors enter into the development of the nervous system of a child, that it is hard to enumerate them all, but I wish to speak especially of physical conditions, or more particularly those of the lower orifices of the body.

Dr. E. H. Pratt, of Chicago, makes this strong statement: "In all pathological conditions, surgical or medical, which linger persistently in spite of all efforts at removal, from the delicate derangements of brain substance that induce insanity, and the various forms of neurasthenia, to the great variety of morbid changes found in the coarser structures of the body, there will invariably be found more or less irritation of the rectum, of the orifices of the sexual system, or of both. In other words, there is one predisposing cause for all forms of chronic diseases, and that is a nerve waste occasioned by orificial irritation at the lower openings of the body."

During childhood the rectum is subject to annoying conditions, as fissure, prolapsus, and especially oxyuris vermicularis. These cause local congestion and irritation, the presence of the worms producing an intense itching, and as they are liable to infest the vagina, will lead to scratching and rubbing over the pudendum that stimulates the sensitive and sensual nerve terminals, and this naturally results in a repetition of the manipulation, and the consequent drain on the nervous system.

Before an obstetrical case is discharged, if the baby is a boy, he is thoroughly examined, adhesions of the foreskin broken up and the smegma carefully removed, and if necessary circumcision is performed—in order to free the system from any unnecessary nervous drain, and by removing these sources of irritation leave no cause to attract the child's attention unduly to this part of his anatomy.

Are the analogous parts of the female child any less liable to irritating influences, any less deserving of attention, or are the structures so small that great harm could be done at this age? If so, when is it best to see that there is no binding down of the sensitive area, no accumulation of secretion behind adhesions?

Cases have come to my attention which have made this question of serious moment. For instance—a girl of the



middle twenties was referred to me as being melancholic. Some years previous she had attempted suicide by shooting, having the idea that she had committed the unpardonable sin. Only then did the parents learn that from the age of six years, she had habitually practiced masturbation. An examination revealed a very tightly adherent hood of the clitoris, and marked improvement followed its release, though the neurotic impress was too deep to be eradicated and the present status of the patient is a form of religious insanity, together with a desire to get the body under subjection, and she is literally starving herself to death in one of our institutions. Could she not have been spared this fate, had that peripheral irritation been discovered in childhood?

Another case was that of a child of six years, restless, peevish, changeable, and at night could not settle down to sleep unless all tired out, but would, as the mother said "fidge, fidge, fidge," and also had nocturnal enuresis, especially on a fidgety night.

Remedies failed to cure the bed wetting, and after some time I learned of these motions, and advised an operation. Though recent the result has been quite gratifying.

A very common complaint among married women is lack of sensation at the time of coitus. This is certainly not as was originally intended, as is evidenced by the anatomy and nerve supply, and is a cause of disappointment to both parties in this normal relation, and often leads to great unhappiness. There are many causes for this, but is there any cause more directly under the physician's control than that of the hooded clitoris, and for that reason, are we not negligent of our sacred duty to *keep people well*, if we do not give the same careful attention to the girls as to the boys?

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### GYNAECOLOGICAL ECONOMICS.

BY

GEORGE P. STUBBS, M. D., PHILADELPHIA.

THERE are two features in the compilation of vital statistics which to me have always conveyed the idea of injustice to an important portion of the body politic. The first is the classification of most married women, those who make home

what it is, the foundation stone of our civilization, as having no occupation. The second, scarcely less unjust, is to label physicians as non-producers. It is to an aspect of this subject I wish to direct your attention.

The present day business world is much engrossed with the idea of efficiency. A general overhauling of business methods, a pruning of all useless motions and wasted energy, is taking place in mechanical pursuits. It is considered paramount that a process of manufacture or accounting that can be accomplished by the use of ten motions shall not be allowed to consume twelve; or that a work normally requiring ten hours shall not take eleven. Efficiency! It is a word to conjure with. For we are assured that the observance of the laws of efficiency will transform certain failure into assured success. The political economist declares that the power, wealth and greatness of a city or state are commensurate with and depend entirely upon the efficiency of its individual citizens. Nor can we fail to agree with the Director of Health of Philadelphia when he says "A nation's greatness depends upon the efficiency of its citizens, personal efficiency depends upon health and sound habits." Here then the health of a city or state is of vital importance to all citizens, and the physician who conserves that health is certainly adding to the productiveness of the state.

Again efficiency, economically considered, does not depend more upon the ability to accumulate wealth, than upon the judgment and thrift shown in spending what has been accumulated. It is possible, as we all well know, to earn a reasonable amount, and yet be perennially handicapped and on the verge of failure.

It is said that four-fifths of the wages earned in the United States are spent by the housewives of the country. And well that it is so. For the thrift, shrewdness, and economy with which nature has endowed womankind have taught the advisability of usually trusting the family purse to her. Therefore the wage earners of our state in the great majority of homes, trusting their wives with the dispersal of their earnings, it becomes of vital import to such homes that nothing interfere with the efficiency of these wives.

I know of nothing (with the possible exception, I am sorry to say, of intemperance) which is so apt to reduce efficiency

as the class of diseases or illnesses called Gynecological. Let us cite an illustrative case:

The family of a mechanic, consisting of father, mother and two children. The father earns \$20.00 or \$25.00 a week most of which he passes over to his wife. She, being well and strong, does most of her own housework, cooking, washing, cleaning, much sewing, nursing the children in their illness, acting as father confessor, and mother comforter, and as an aside paying the rent, purchasing the provisions and clothing, and by dint of much thought and planning, putting by a little for a rainy day. All of which entitles her to be classed among those having "no occupation." And well she earns the honor for no land can long prosper without many such many-sided women. So the little family prospers. But mother falls sick. She does not go to bed; she does not get pale and thin. Indeed her husband can hardly believe she is sick. But this awful backache will not let her wash and someone must be paid to do it. Later she cannot run the sewing-machine and more money goes out to the dressmaker. Soon it is necessary to get some one in to do the housework, and the savings begin to dwindle. Then one of the girls must stay away from school to help at home. After a time the children's health begins to show the lack of properly prepared food. John fails to understand this strange illness which does not put his wife in bed, but keeps her on the couch most of the time. He gets impatient and she gets despondent or morose. And for what? Because her efficiency has been reduced by a prolapsus uteri, a pelvic cellulitis or some other gynaecological condition. An attack of fever, pneumonic or typhoid, even a fractured bone would deprive the household of its chief dependence for only a few weeks, but this complaint seems interminable and indeterminate. It presents a most serious economic problem. How shall we estimate the cost of such an illness to the family? If it is equally as important to conserve as to acquire a certain wage, we must assign 50 per cent. of value to the work of both husband and wife. It is undoubtedly true that most ailments such as described above would reduce a woman's efficiency at least one half. Therefore we have a total reduction of 25 per cent in the family efficiency. A matter of no small moment to a man earning a moderate salary and to



whom every dollar is of importance. In practice this estimate is rather under than over the facts.

It was my privilege two or three years ago to restore to her former degree of efficiency a woman who had been invalided for several years. An anterior colporrhaphy followed by a properly fitted pessary was all that was required. She gradually assumed her former place in the household and her husband recently told me he had no idea her illness was costing him so much. Since the recovery of his wife he has been able to clear off old debts which had completely baffled his previous efforts and was again building up a little bank account. He is a mechanic on an ordinary wage, and his wife's illness had been the deciding factor in the family prosperity.

Another case, Mrs. K. had recurrent attacks of pelvic cellulitis complicating a chronic salpingitis. Mr. K. is a policeman earning about eighty dollars a month. For two years a daughter ambitious to become a teacher, was compelled to forego her studies in order to help at home. Much expense was incurred in hiring service formerly performed by the mother. After three years the family was becoming embarrassed financially. A suitable operation has restored the wife to her family, the daughter has resumed her studies for a useful pursuit, the husband free from debts goes on his rounds with a cheerful mind, and the city and state are certainly the gainer. And yet the physician or surgeon who has accomplished this desirable result, who has given the state three efficient citizens in place of one discouraged man, one weakling, and one child deprived of its birthright, is classed as a non-producer. And this in spite of the fact that his work will add to the wealth of the state for years to come.

I hold no brief for the lawyer or minister or teacher. They may or may not be non-producers as the census compilers say. But I submit that it is possible to produce other things of value than those made of iron or wool, and one of those products is health efficiency, than which there is nothing of more vital importance to the city or state.

The particular feature that concerns us in cases such as cited, is the essentially long course that the greater number of gynecological cases run. Being of so much import to the

family prosperity, they become of interest to the state also, if found to be very numerous. It was to decide this question that I made a somewhat extensive examination of the hospital records of the City of Philadelphia.

Exclusive of special hospitals, such as stomach, eye and ear and children's hospitals, there are in Philadelphia 32 general hospitals maintaining an ambulance service. Of these sixteen, or one-half, were examined with the object of ascertaining what proportion of all the cases treated were gynaecological. These sixteen institutions reported last year a total of 32,377 persons admitted to their wards. Of these 5,269 were gynaecological cases. This is 16.1-4 per cent. of all cases, medical, surgical, and accidental, no mean percentage when we consider the large accident service occasioned by the numerous manufacturing plants and railroads of this large city. If we consider these sixteen hospitals as representative of all, we have a total of 10,538 gynaecological cases coming to the hospitals in one city alone. Philadelphia comprises approximately one fifth of the population of the state of Pennsylvania, which gives us a grand total of 52,690 gynaecological cases in one state in one year. This total would doubtless be somewhat reduced by the fact that many cases are attracted to the city by greater hospital facilities. But even so reduced the total will indicate an economic problem of no mean proportions to the families of our state.

When we turn from the consideration of the number of cases to their character and treatment the figures are still more surprising. The same sixteen hospitals reported a total of 14,421 operations of all kinds and grades 4,813 of which, and constituting 33.1-3 per cent. were gynaecological operations. In other words while the gynaecological cases were but 16.1-4 per cent. of the total number, the gynaecological operations were 33.1-3 per cent. of the total operations performed.

We are here confronted with an interesting query. Is the great increase in the number of gynaecological operations over other classes of operative work, due to the inherent and essentially surgical character of the cases, or to a diminished therapeutic efficiency? The answer to this question would possibly be easier could I state the number of plastic cases represented in the figures given. This however, I could

ascertain from the data in only a few of the institutions examined. Even allowing for such parturient injuries as are unavoidable and require operation, I am of opinion that the percentage is much too high to find justification, and demands revision of our method of treating many gynaecological conditions.

In examining dispensary reports a reverse state is found to exist. For while a total of 165,321 cases are reported, only 8,158 or 4.7-8 per cent. are gynaecological. I was at first inclined to ascribe this low percentage to the influence of teaching institutions keeping women away from their clinics. This however, is incorrect, as is shown by the fact that the University of Pennsylvania, a teaching institution, shows a dispensary gynaecological report of 3.1-4 per cent. of the total, while the German Hospital, a non-teaching institution, shows only 3.1-2 per cent. and the Methodist Hospital but 2.1-3 per cent. of gynaecological cases. The reason for this disparity of hospital and dispensary cases is to be sought, I believe, in feminine human nature. Woman seems bound to consider herself as born to suffer, and suffer she does in many, many weary bodies as long as endurance will allow. When she wakes to the need of action it is all too often time for the knife and not for milder treatments. Consequently, while a very small percentage of gynaecological cases present themselves for treatment (4.7-8 per cent.) a very large proportion (33.1-3 per cent.) come to the operating room.

To me it appears that here lies our duty, to decrease the one and to increase the other class. Signs of an awakening of interest in this subject are not wanting. In a recent number of the *American Journal of Surgery* Brickner calls attention to the abuse of the uterine curette, as for instance, making it a routine matter in plastic work on cervix or vagina, saying "this is no more rational than would be curettage of the nasal mucous membrane as a part of an operation for hypertrophied turbinate or polypus," while R. T. Frank in the *New York Medical Journal* deplores the fact that out of 2000 consecutive dispensary cases "more than one in every five of these had been curetted at some time." Both of these authorities claim, I think justly, that the abuse of curettage increases the number of parametric and tubal in-



inflammations, which lesions add years to the suffering and inefficiency of the patient. Many of these cases would not have been curetted had they been thoroughly examined, and parametric inflammation, gonorrheal cervicitis, pus tubes, etc., been found to account for haemorrhage or leucorrhoea.

The use of pituitrin in dystocœa as tending to reduce the need of forceps and its consequent injuries, is a therapeutic weapon that should be welcomed as conservative of feminine efficiency. I. S. Wile in an article on Surgical Sociology makes the statement that "a conservative estimate would place the number of deaths from the direct and indirect causes of labor at 20,000." Liepman enthusiastically urges the use of pituitrin before resorting to forceps operations in all cases, and even believes that Cesarean section should only follow the administration of this agent. Any therapeutic measure which will lessen obstetrical operations should receive a thorough investigation as tending to decrease the subsequent gynaecological lesions.

These are but suggestive illustrations in which a study of surgical methods and an elimination of avoidable operations may make for increased efficiency to our gynaecological patients.

Our investigation, however, should go back farther than parturient women, and begin with the puberty of the child. We are often inclined to be content with the diagnosis of puberty, when a careful examination would change our idea of a case. In these days of the germ no case of leucorrhœa should be passed without a hunt for gonococci merely because of the age of the patient. An amenorrhœa may disclose imperforate hymen or infantile uterus, and not infrequently have I found vague pelvic distress in a young girl (in one case as young as twelve) and which had been ascribed to puberty, to mean pus tubes.

Let us recollect also that conservation does not always mean to refrain from operations, but to operate more thoroughly. Efficiency does not result from an operation which stops half way of the mark of functional health.

For instance, Miss T. had the right ovary removed. The left ovary is rather uncertain being slightly cystic, but is not disturbed and after a few months of comparative health the old symptoms of pelvic inflammation return and are en-

dured for two or three years. Then I removed the left ovary and tube with a return to health that is permanent till to-day. I contend those three years of inefficiency, with their suffering and loss of time from work, should have been spared this patient. Do not misunderstand me. I do not stand for the sacrifice of organ or tissue, only for conservative thoroughness, that which will bring the greatest degree of efficiency and bring it as quickly as possible.

A year or two of medication where treatment is required, or of local applications where operation is indicated, means a loss of from one to three hundred dollars to the average family, and outside of the suffering involved, we as conscientious public servants, can not be a party to it.

Therefore we are bound to examine our gynaecological cases early, thoroughly, and not neglect the cases of puberty; to avoid meddlesome operations but to operate thoroughly when indicated. In this way shall we increase in our patients that efficiency which is so important to family and state, and lastly refute the injustice of being classed as non-producers.

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## BUREAU OF OBSTETRICS

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### THE CONSERVATIVE TREATMENT OF ABORTION.

BY

EDWARD P. CLARKE, M. D., PITTSBURGH.

THE continued use and abuse of the curette in cases of abortion, and the high mortality and morbidity attending it, is the only excuse I offer for calling the attention of this Society to the subject of abortion and its treatment.

The majority of these cases are treated by the men in general practice and by men who do not enjoy hospital facilities, consequently, if we can suggest a method which can be used in the home it should be of practical value and worthy of our discussion.

Dr. Watkins of Chicago has outlined the conservative treatment of abortion as follows:—(Surgery, Gynecology and Obstetrics Vol. XIV No. 1.)

1—Fowler's position.

2—At least two quarts of fluid to be taken daily.

3—A large amount of nutritious food.

4—Keep the patient out of doors if possible, and daily sun baths.

5—Relieve pain and produce six to eight hours sleep.

6—An ice bag to the abdomen.

This treatment you will perceive is entirely to increase the patient's resistance, and is suggestive of our modern treatment for tuberculosis, typhoid and pneumonia.

Dr. Emil Reis says, "I would not enter a puerperal uterus except for a dangerous hemorrhage."

Dr. Watkins does not disturb the uterus except for hemorrhage or where the placenta or membranes are *known* to be present.

Dr. Murphy even advises against a vaginal examination if the diagnosis is clear without it, because of the great danger of carrying infection in from without. If it is necessary, however, our antisepsis must be as nearly perfect as possible.

Fowler's position is not a very essential part of the treatment. It is supposed to aid in confining the infection to the pelvis where absorption is not so rapid as in the upper abdomen. If it interferes with the patient's rest I believe its doubtful benefit should be sacrificed for the greater advantage of rest and comfort.

It is sometimes difficult to give these patients two quarts of liquid daily by mouth, especially as vomiting attends the more severe cases. I use enteroclysis in all these cases as it helps supply the liquid required and also aids in controlling the infection. I find also that Murphy's drop method is difficult to use, even with the help of a trained nurse, because the water usually enters the rectum cold and is promptly expelled. Also the continued presence of a tube in the rectum is both irritating to the mucous membrane and annoying to the patient. Consequently, I have adopted the Ochsner method of injecting four or six ounces of saline into the bowels every four hours.

A large amount of nutritious food is also rather difficult to administer in cases of nausea and vomiting. We must therefore select our diet very carefully, and if necessary augment it with rectal alimentation. The retention of food is



much interfered with if these patients are given a general anesthetic; therefore, it should never be given except for rapid dilatation in cases of hemorrhage.

Keeping the patient out of doors is not always possible, but they can certainly be drawn close to an open window, and if possible lie in the sunshine for a few hours each day.

Dr. Watkins relieves pain and produces sleep by the administration of morphine. In extreme pain or great restlessness this may be required, but it should be dispensed with as early as possible. The administration of stimulants such as strychnia or whiskey is sure to interfere with sleep.

An ice bag to the abdomen is of doubtful benefit. If it relieves the patient, I employ it, but if it causes annoyance I dispense with its use.

Pelvic abscesses are let alone by Watkins and Goldstein, while Reis and Kolischer condemn this as dangerous practice. Perhaps the middle of the road course is the safest. While the symptoms are severe and the infection intense, the patient should be kept quiet and nourished. After the storm has subsided the abscess may be opened and drained to save a possible perforation into neighboring organs. We do not operate pus tubes until after the inflammation has subsided and the pus becomes sterile, and I believe the same rule obtains in pelvic abscess.

Where we know the placenta or membrane are retained, the cervix and vagina may be packed tightly with gauze for twenty-four or forty-eight hours until the dilatation is large enough to admit a small placenta forcep and then under morphine or scopolamine the offending tissue is very gently removed. In many cases the packing alone is sufficient to empty the uterus.

With hemorrhage it is sometimes necessary in order to save life, to divulse under a general anesthetic and immediately remove the fetus, but if the bleeding is not serious, the slower method of packing and removing without anaesthesia leaves the patient in better condition to fight infection.

Sapremia is not considered a very dangerous condition and the patient will recover if let alone. It is often changed into a more severe type by means of the curette. Septicemia is a very serious condition, the infection is scattered through-

'out the system and the relief or death of the patient depends entirely upon their resistance. We are certain at least that a curettage will not help a general infection—it has progressed beyond local aid.

I have treated cases of abortion by using the curette; I have tried to empty the uterus with the finger alone; I have packed with gauze and injected alcohol through a catheter to kill the infection, but I believe these methods produce trauma, interfere with drainage or decrease the resistance of the patient. I am convinced that the conservative treatment of abortion will decrease our mortality.

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### OBSTETRICAL EXAMINATION.

BY

A. G. C. STETSON, M. D., PHILADELPHIA.

BECAUSE I feel this subject merits attention, I beg to bring it before you, and ask your consideration of its importance. On account of the advance in this science, many points have come to prominence, which points give us better means of diagnosis, and suggest therapeutic measures to be instituted to prevent conditions arising, that may embarrass the practitioner seriously, in the course of his case. Colleges recognizing these points, have so planned their teaching as to enable the new graduate to approach his case with a thorough knowledge and without fear and trembling.

Too frequently do general practitioners know little more of the case at hand, than that she last menstruated on such a date and that she will probably fall into labor, on or about another set time; and they rest comfortably in the fact, that statistics tell us, that 98 per cent. of cases are normal and will probably deliver themselves, if left alone, and no untoward circumstances will complicate. It is for the other 2 per cent. that I plead; that the care of all cases should be conducted carefully and scientifically, so that these 2 per cent. may be numbered with the 98 per cent. if it be possible. I believe the true physician who (by his careful, systematic examination, and his close noting of any symptoms that may appear) is able to save a few of this 2 per cent. will feel

amply repaid for all the care bestowed on the entire 100 per cent.

Probably you have heard some one boast of his success and few deaths in confinement. Such boasts may cover a multitude of mistakes and I think he had better "touch wood." Some older practitioners may say, "Before such a thing as sterilizing of instruments, gauze, cotton, etc. or the present idea of cleansing the hands was thought of, I handled cases just as successfully as they are handled now." But we cannot prove that he is telling an absolute truth. Still we may in charity, give him the credit of thinking he is. If however, he continues his old way, after these precautions have been for years forcefully brought to his attention, it is a grievous fault and grievously will his patients answer for it and he too a little later on. Let us say to him, science will advance, newer and better methods will come, because there are among many doctors some physicians. "Times change and people change, woe is he who changes not with the times."

The average general practitioner feels he has not the time to devote to the pregnant woman, that a specialist would think he should. To him let us say, "what is worth doing is worth doing well." He possibly examines the urine "after a fashion," but he does not give a thought to external or internal examination or to pelvimetry, or if it is suggested to his mind, he will say, "Patients will not stand for it." I think if the doctor will take a little trouble to explain the importance of his having a thorough knowledge of the case, and the consequences that may accrue if he does not, the patient will readily submit. If she does not, he is justified in letting some less conscientious man handle the case.

Sometimes the case is prolonged and he (the busy general practitioner) has other cases that demand his attention and he must be off, so he puts on the forceps, regardless of what the result may be, so long as he gets away. Or in his uncertain diagnosis, begins to manipulate unduly, and so runs the possibility or more properly speaking the probability, of causing infection. Without history and examination, the presence of syphilis is overlooked and the existence of gonorrhoeal infection unknown, the proper therapeutic measures omitted and the results of these follow. The size and shape of the



pelvis disregarded and he comes up to the beginning of labor, and finds himself confronted with difficulties of which he knows nothing. Such ignorance or neglect, on the part of one who assumes to be competent or represents himself so to be, is little short of criminal.

Doctors, we must awake, we must advance, if only for the lowest of motives, (personal,) for the laity are reading and becoming wiser, and ere long they will not stand for "antiquated methods." They will demand the newer and more scientific way, indeed the time is at hand, and now is, that they are calling for the specialist.

In order to have success and to merit it, we must adopt a systematic method of examination. It is well to start at the earliest possible moment; as soon as we have the case intrusted to us, with getting, first: History, and second:

Examination—General—Heart, Lungs, Urine. Special—External, Internal, Pelvimetry, External, Internal.

History includes the patient's age, parity, her diseases of childhood and maturity, menstrual history, history of previous pregnancies and labors and health in present pregnancy, health of previous children at birth. Does she have any headaches, the extent of nausea and vomiting, edema, trouble with eyes, loss of weight or gain, appetite and bowels, pressure symptoms and loss of blood. The husband, his age, and the diseases he has had. The family history as to chronic infections and malignancy. The heart, look carefully for lesions, old or new, by the knowledge of them, we may save a patient from collapse, due to sudden lessening of intra-abdominal pressure, after prolonged over exertion or from loss of compensation due to strain and increased effort put upon the heart.

Blood pressure is of extreme importance as it helps us in guarding against and in the early recognition of the toxemias of pregnancy. Of course we do not consider this absolute, but authorities state that an increase to 150 MM of pressure indicates something wrong with the heart, arteries or kidneys for, in the normal pregnancy, the pressure is not disturbed, so if we find symptoms that would suggest toxemia and the blood pressure is altered, it is our business to find out the cause.

*Lungs.*—We should recognize at once lesions of the lungs, especially a tubercular lesion, for pregnancy excites the ex-

isting lesions and causes a more rapid progress of the process, so much so, that the patient usually succumbs in a few weeks after delivery. Consequently, we should be on the alert and if the patient has an active lesion and is seen in time, say before the fourth month, the immediate interruption of labour is indicated. But if the harm is done, and some progress has been made, (as we would more likely find, after the fourth month,) it would probably be as serious for the mother, to interrupt, as to allow the labor to go on.

*The Urine.*—Not only the chemical, but also the microscopical examination should be carried out with care and above all other information that we can gain (that is, for the purpose of discovering the probability of a toxemia being imminent) is the total nitrogen and the estimation of the nitrogen in the ammonia as compared with the total nitrogen. This of course cannot be well done in one's office, so a trained chemist should be consulted. The reason of the importance of this, is that it is an accepted fact, that the toxemias of pregnancy are due to some alteration in the metabolic activity.

The pernicious vomiting of pregnancy. The ammonia coefficient is high, varying from 10, 20 to 40 per cent.

In Nephritic toxemia, the quantity of urine may be normal or increased, with large amounts of albumen or casts, the total nitrogen may be normal and the ammonia coefficient normal or decreased.

In Pre-eclamptic toxemia, the urine is considerably diminished in quantity, the total nitrogen and urea greatly decreased.

In Eclampsia, the albumen is present in large quantities, the nitrogen usually diminished, urea diminished markedly. Ammonia coefficient at onset of convulsion, is decreased, followed with a marked rise and it remains high for a variable length of time.

Now the special examination. The breasts, size, consistency, secretion, superficial veins, and nipples; Care to prevent fissures and cracks during lactation, begins with keeping them soft, clear and free from scales during pregnancy. If a nipple is inverted, proper means applied before labor may rectify it.

*Abdominal.*—By this we learn much of importance, the direction of the uterine axis, the position and presentation.

location of foetal heart tones and its differentiation from other sounds heard, relation of child's head to the maternal pelvis, any overriding of the head at the symphysis, etc. If there is no engagement of the head it should be forced into the pelvis and held by an assistant, while the relation of the head to the sacrum and symphysis are studied by internal examination; see that the major portion of head is below sacral prominence. A head, too large resting on the base of the sacral promontory may show no over riding externally; yet, internal examination, in relation to the promontory, shows at once a marked disproportion.

The method of making this examination is easily described but the ability to detect the finer points, is only acquired after much trying. With internal examination, we must do away with the old idea of making it under cover and begin with inspection and palpation of external genitalia. Here, we must note the presence of venereal diseases, lacerations, varicosities, tumors, condition of hymen if present etc.

*Vagina.*—Condition of walls, hypertrophy, atrophy, varicosity or any condition that may interfere with the passage of the child. Note the general contour of the pelvis, distance between ischial tuberosities and angle of the pubic arch.

Cervix, its length, consistency, pabulous, or not, or anything protruding from it.

Note any retro displacement of the uterus and replace it early, although it may sometimes right itself, but it may cause abortion or become incarcerated. Later in the pregnancy confirm your external diagnosis, as to position, presentation, and relation of presenting part to the pelvic inlet. At this time you may take your diagonal conjugate and if you will bear with me, I will describe the method taught in the Hahnemann Hospital. The index and middle finger are held closely together and pressed into the vagina, in the direction of the long axis, until the sacrum is felt, the finger is then carried up the anterior surface of sacrum, until the prominence is felt, holding this point, the radial side of the hand, is brought in contact with the subpubic angle at its apex. This point of contact is then marked by the nail of the index finger of the opposite hand, and measured when withdrawn. To get the true conjugate, subtract 1.5 or 2 C. M. In case of rachitis pubis, always subtract 2 M. according to the obliquity of the symphysis. Now, at times the perineum is found to be



rigid and you cannot reach the promontory of the sacrum, but you can assure yourself that it is sufficiently large, if you are reaching in the right direction; but it is wiser to use one of the instruments devised for the purpose and get accurate measurements. This brings us to the subject of pelvimetry. One has said that the doctor who practices obstetrics, without the use of pelvimetry, is no better than the one who treats chest diseases without the use of auscultation and percussion. It is *one absolute necessity* and to take the external, without the internal, is misleading in all cases. Thoroughness and completeness is our only safe course.

*External.*—Introspinous, intercrystal, intertrochanteric and external conjugate and if you suspect any asymetry, the external oblique conjugate.

*Internal.*—The diagonal conjugate and the distance between the tuberosities of the ischium. This latter, is more important than some have considered it, for if this diameter is short, the subpubic angle is lessened; the head cannot pass here and the delivery depends on the distance between the tuberosity of the ischium and the tip of the sacrum.

The external conjugate may approach the normal and the internal may be small, the difference being due to thickness of sacrum or symphysis, or to the inclination of the pelvis.

This general method of examination, I leave before you, and in doing so, I again plead for a systematic, careful, observation and examination of our cases, with the hope that some valued lives may be saved to our respective communities.

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CONGENITAL FAMILY STEATORRHEA.—In the *Quarterly Journal of Medicine* for January, 1913, Garrod and Hurtley describe the strange case of a boy, aged eight, who has been subject from infancy to the passage from the bowel of liquid fat, which solidifies on cooling. He is the second of five children, whose parents are first cousins. The fifth child, now dead, was similarly affected. There are no other morbid manifestations and no indication of any disease. However much or little fat be taken, some 25 per cent. is thus lost in the stools, and it is supposed that he is the subject of a rare inborn error of fat absorption, "probably a Mendelian recessive characteristic," although so far investigation has not determined wherein the error lies.—*Archives of Pediatrics*, October, 1913.

## NASAL POLYPI.

BY

GEORGE JAMES ALEXANDER, M. D., PHILADELPHIA.

(Read before the Germantown Medical Club.)

BECAUSE of the frequency of their occurrence; and their important relationship to other deeper seated pathologic conditions within the nose, I was led to select the subject of nasal polyps as the theme for my paper this evening, hoping thereby to share with the general practitioner some recently attained knowledge upon this subject.

Until a comparatively recent period nasal polyps were considered quite a separate chapter in works on Rhinology. Zuckerkandl through his exhaustive researches into the anatomy, both *normal* and *pathologic*, of the nose and nasal accessory sinuses, has cleared up this previously somewhat misunderstood subject. He has demonstrated the fact that nasal polyps are really *oedematous hyperplasias* of the mucous membrane, also that they are no different in construction from the hypertrophies and hyperplasias found on the middle and inferior turbinates, as well as on the septum, (the latter not being so common.) Differing perhaps only in consistency and shape, which in the case of polyps is very characteristic;—soft, oedematous, usually pedunculated, and the hypertrophy a sessile papillary mass found on the inferior tubinate, and a second type which is a thickening of *all* the layers of the mucous membrane of the middle turbinate, because of a denser connective tissue at this part, it is rather firm and smooth; and on account of its location is often mistaken for a polyp by the untrained eye.

*What are nasal polypos?* They are oedematous, succulent, translucent, jelly like, greyish red swellings of the mucous membrane, usually bathed in a sero-mucous fluid. They may occur as diffuse thickening, (sessile) or pedunculated. The latter varying in size from that of a small pea to that of a chicken's egg. Round, in many instances, but may contain indentations of the surrounding parts or molded into certain shapes by the same means, and are suspended from the lateral wall of the middle meatus, (one of the sites of predilection). Occurring always on the free borders of certain anatomical

structures namely, the middle turbinate, bulla-frontalis, processus uncinatus, infundibulum, etc. In clusters or singly, are soft to touch and freely movable with the blunt probe. Unilateral in about fifty per cent. of the cases. The topography of the parts may be completely changed because of the size. They sometimes entirely fill the middle and inferior meati, obliterating absolutely all the anatomical outlines. Again, normal anatomy is displaced by pressure caused by the polyps. (Notably middle turbinate and septum.) Again, they are found in the inferior meatus on the floor of the nose, with a pedicle extending up and attached to the middle turbinate. Still another variety whose pedicle can usually be traced to the accessory osteum of the maxillary sinus, located about one half to one centimeter behind the natural osteum, in the fontanel or membranous portion of the median wall of the sinus. (Constant in one out of five cases according to Zucherkerndl.) Causing the polyp to take a downward and backward course and lodge in the pharyngeal orifice or choana, between the posterior ends of the middle and inferior turbinates. It may entirely occlude the choana and again has become so large that it was seen through the mouth, extending below the soft palate. This one receiving the special name of *choanal polyp*, which by the way is a misnomer, inasmuch as such a thing does not exist, merely deriving this name from its *position*. And, as we have seen it can be traced back to its origin in the *maxillary sinus*. We have what might be termed several different types of polyps, which are really only different stages of advancement of the same process. For example: (a) There is a diffuse oedematous enlargement of the mucous membrane on any of the parts in the middle meatus.

Notably the middle turbinate which is usually called by the rhinologists, *Polypoid degeneration*; but it is practically the earlier stage of the one that is to follow. (b) The pedunculated variety, attached by its pedicle on the distal end of which is the body or pendent. Its character we have already studied. (c) Lastly comes the interesting cystic type. It is generally of some size, its external appearance being exactly the same as that of the pedunculated or type (b), including the pedicle and pendent. The resistance on palpation with the probe is the same. This polyp is histologically the same



as the other types, with the exception that it has a cavity inside, and is divided into two varieties, because of the different method of development of this cavity, namely, (a) *cystic degeneration*. Here the formation follows the breaking down or degeneration of a gland with a destruction of the columnar ciliated epithelium, surrounding a cavity filled with debris and serum; while the other form (b) *cystic dilatation*, is a simple dilatation of a gland, edges lined with columnar epithelium, and the cavity distended with serum.

In studying a polyp microscopically we find it has all the tissue characteristics of the mucous membrane of the nose i. e. they are covered with columnar epithelium, contain glands and blood vessels, horizontal and longitudinal, (the latter being very characteristic of a chronic inflammatory process), fibers of elastic tissue and very loose connective tissue with large meshes which are distended with retained and coagulated serum. Many round cells near the surface, often find stratified epithelium which looks white and opaque.

There are two other conditions which should be briefly alluded to in connection with these polyps, namely, (a) The *fibromatous polyp* which is very rich in connective tissue and hard to the touch. (b) *Angio fibroma* which is wrongly called a bleeding polyp. Clinically this has been mistaken for a polyp even though the characteristic bluish color and small hemorrhages were present. Latter being caused by little ulcerated areas due to exposure to dust and other irritating substances. And with the microscope we find the fibrous tissue in which there are many blood spaces. Fibrous cells have many nuclei, and run in many directions. The epithelium being stratified.

#### CAUSE OF POLYPS.

A variety of explanations have been offered as the cause of nasal polyps, many of which are rather vague. My own belief is that polyps are principally the result of *Sinusitis*, (inflammation of the nasal accessory sinuses.) Polyps are rarely found in children, because they have imperfectly developed sinuses. Only six cases were found in ten thousand patients over a period of ten years. The youngest being six and a half years (Lacoarret, Rev. de Laryngol xxii., 1902, No. 37 P. S. 33.) Because of developmental reasons

then, we can be reasonably sure that those six cases were due to some one of the remaining less frequent causes of polyps. They are more frequent in men than women. St. Clair Thomson says they occur chiefly between the age of twenty and thirty years. The clinical observations of the writer, however, places them between the ages of thirty and seventy. In choanal or *naso-antral* polyps I have observed that the patients' ages ranged from eighteen to about thirty years, while Brown Kelly says they are more common under twenty years of age. True enough, the foundation can be and is laid very frequently at, or shortly after the development of the sinuses, by attacks of *Rhinitis*, *Influenza* or any of the exanthematous diseases, which leave behind one or more diseased sinuses. This in turn is followed by a polyp formation which is a relatively slow process and the patient does not realize the presence of a pathological or abnormal condition in the nose until it appears as an obstruction to breathing. (Together with several other important symptoms which they do not associate with the obstruction.) This is a slow procedure in most instances, hence my reason for saying that the rhinologist first comes in contact with these cases mostly at a late day, from about thirty years up. As to the frequency of their presence Zuckerkandl has found one in every eight or nine cadavers. Clinically Morell MacKenzie met with one in every twenty patients.

St. Clair Thomson gives a very elaborate classification of causes of polyps under four headings:

1. Physical causes.
2. Irritative causes.
3. Inflammatory causes.
4. Nervous causes.

These are further subdivided, making a very long list, most of which are unimportant and rare. Since it is within the bounds of this paper to include the most important facts on the subject, I will mention but a few of the more essential ones.

1. Those due to *foreign bodies* in the nose are not so common, because of the skill of the rhinologists to recognize its presence before the secondary condition takes place. i. e. polyp formation, and when present, is located at a point around the foreign body.

2. Polyps occasionally follow *Local Traumatism*, which for some reason does not heal promptly. Particularly interesting, however, is the difference of opinion concerning the relationship of polyps to the underlying bone.

Woaks, Lack and Packard contend that the disease is primarily in the *bone* under the polyp, extending outwards, including the mucous membrane; and such men as Hajek and Wright, that the degeneration begins in the *mucous membrane*. We will see the truth in the mucous membrane opinion as we take up the analysis of the principal cause of nasal polyps. *Chronic Sinusitis*, most frequently the antrum, and secondly the ethmoids. This condition is a sequela to such primary causes as *Acute Rhinitis*, *Influenza*, *Measles*, *Scarletina* and very frequently to *diving into deep water*. The latter getting into the antrum and setting up inflammation of its mucous membrane lining. These inflammations go from the acute to sub-acute and chronic stages. The mucous membrane first becoming thickened, and later forms a polypoid degeneration and polyps in the sinuses which may be so numerous as to completely fill the cavities. From this there is a constant outflow of muco-purulent or thick watery discharge into the nasal cavities, dripping over and affecting more particularly the most prominent ledges of bony structures i. e. Uncinate Process, Bulla Ethmoidalis, Middle Turbinate and Ostei of the different sinuses. In turn setting up a secondary inflammation and degenerative process in the mucous membrane covering these bony structures, which at first becomes thickened and later oedematous. Now it must be clear to all that at this time there is a mechanical aid coming to the assistance of an already existing pathological medium working very harmoniously for the construction of the end product; "A polyp." For is it not the most reasonable thing that as the oedema increases, the more heavily it hangs over these bony ledges, and the more stasis must be the result by cutting off the capillaries. Sometimes a gland will become greatly distended with serum by the closure of its duct, producing a cystic polyp, and again there may be a degeneration of a gland from pressure, stenosis, etc., causing a cystic degeneration polyp. The foregoing will enable you to form an accurate opinion, which is the *primary* offending tissue. The bone or the mucous membrane. Woaks' theory of necrosis



of the underlying bone, *necrosing ethmoiditis*, is a very pretty one, but what he really feels with his probe is the grating of a new bony formation, or growth, and not a necrosis. This is very fragile and breaks easily on being touched with the probe. What does occur, according to Hajek, is a resorption of bone, an atrophying process which arises in the mucous membrane surface and extends deeper and deeper to the cortex of the bone. When finally this resorbing process reaches the bone marrow, polyps follow as a result. In summing this up I have endeavored to show then;

*First*, that polyps are secondary to an inflammatory state elsewhere than at seat of polyps, *Secondly*, that they are not due to necrosing bone, and that the primary cause elsewhere is having its origin in the mucous membrane, which finally involves the bone by resorption.

#### SYMPTOMS.

When observing the symptoms of polyps, about the first sign that confronts one is a picture of nasal obstruction, accompanied by the characteristic watery discharge, as was stated in another part of this paper the development of polyps is so gradual that the obstruction or occlusion with its various symptoms is quite a long time in making itself manifest, particularly to a point of discomfort, because the patient becomes more or less accustomed to their presence. Thermic changes affects these growths very materially, being much larger in cold damp weather and diminished when the weather is warm and dry. The obstruction may be so great that the patient will have a constant excoriating watery discharge from the nose as if he were having repeated attacks of rhinitis.

There is frequently a loss of sense of smell when the middle meatus is obstructed. The patient may manifest the so called nasal tone to his speech, which is a falsely applied term since the sound is not produced by its passage through the nose, but by the obstruction. A portion of the discharge can drip backwards causing a post-nasal catarrh, and an increase in size and number of the pharyngeal follicles, (Pharyngeal Catarrh, secondary) or dry, and cause a Pharyngitis Sicca. Also catarrh of the eustachian tubes which at times extends to the middle ear. A very common and simple sign you all have noticed, is, the patient closing the mouth and naso-

pharynx producing an air pressure, then suddenly releasing the soft palate, allowing the air to rush through the nose temporarily overcoming the obstruction.

Several of the more important *reflex symptoms* are, headache in the frontal region, asthma and emphysema, the asthma element being present in most of the older patients and many of the younger ones.

On examination of the nose we may find a number of diversions from the normal anatomical form due to pressure. The nose can be packed so tightly with polyps that the nasal bones will be markedly pressed outward and the bridge of the nose much broadened, and the bones may even be separated from each other. However, in some cases this broadening may disappear, after removal of the offending polyps. Inspection of the nasal cavity will show many forms of polyps from small to very large single ones that will occlude the entire nasal chamber, growing in such a way that they look as if they were moulded to the parts. Again we have great masses formed by numbers of these round, greyish yellow, glistening bodies which look almost the color of clouded amber, only more translucent and are not so typically pedunculated as the single ones.

Upon exposure to the air and dust they become dry and darker in color, the wall becomes stiff, resistant and graty to touch by the probe. When they are present in large masses in the middle meatus, under the middle turbinate pushing it upward and inward toward the septum, they are coming from diseased *anterior ethmoid sinuses*, and when they appear in the middle meatus with the pedicle over the uncinate process they are from the *frontal sinus* or *maxillary antrum*. The exact position can better be determined after shrinking, by the use of twenty per cent. cocaine, applied on surrounding parts. But one must always make a careful observation before using cocaine so as to familiarize himself with the anatomical outlines and compare the difference which follows. You might ask if the cocaine would not defeat one's purpose by altering the size, color, etc., of the polyps. To such a question I may say that cocaine has very slight if any action upon this distended polyp tissue, but furnishes indispensable aid by its narcosis, shrinking and blanching of the surrounding parts in the nose. Polyps are rarely found in the olfac-

tery fissure. When polyps are found in large numbers they are usually quite small. There may also be a very large one with a number of quite small ones surrounding it. The very large ones not being so easily movable, because of their size and short pedicle. This is also true of the choanal polyp, which is single and may be found so large as to extend, and be visible below the soft palate, in the pharynx; and is the result of the antrum cavity being so crowded with polyps that any further growth is forced outside, through (in most instances) the *accessory ostium* of the antrum, which in my own observation proved to be present in one, to three or four, a higher percentage than that of some other observers.

St. Clair Thomson cites such a growth presenting in the pharynx as described above, and says it is from the ethmoid sinuses. This is probably a mistake, if Hajek is right, because he says they all come from the *antrum of Hymore*; though it seems possible to the writer that they could come from the *posterior ethmoids* or even the *sphenoid sinus*.

*Transillumination* may be found interesting in polyp cases. Not because of the polyps themselves but because of the frequently associated sinus disease; in which event we find the dark shadow corresponding to the sinus affected. There is no difficulty attended with the discovery and diagnosing of polyps, yet they are often mistaken by the less experienced, for drops of mucous, middle turbinate, uniform process, hypertrophies, deviations and spurs. But, with a little experience, if the examiner will cocaineize and use the probe, (the rhinologist's third eye) he cannot mistake this growth for anything else; for there is nothing similar to it in the nose, unless it would possibly be a hypertrophy. Even then, locality, color and shape would be apt to save one from such a mistake. However, the regularity and frequency with which they are overlooked is rather surprising. Papilomata and Fibromata are two other conditions of nasal growths which may confuse the less experienced. But the former while it is soft, is irregular (as a cauliflower) and the fibroma is opaque, dense, hard and smooth. At all events both are rare in the anterior portion of the nose and need cause very little concern.

If there is a question of malignancy which might be hid-



den by polyps, you will know it by the spontaneous bleeding, early ulceration and rapid growth of the polyps, all of which is just the opposite in the instance of mucous polypi.

We should be careful in giving a prognosis, as to recurrence however, not as one writer puts it, because of the possibility of finding associate sinusitis or hidden growth; but, because after removing all the visible polyps, as Hajek claims, there are small ones situated in cavities which cannot be seen or reached with the snare or forceps, and because of improper removal of those attached. These grow and cause an apparent recurrence. He says that a relapse is an absolute false statement because of the above reason. Personally I must admit that it is not quite clear to me, why a polyp cannot recur from the same cause that produced the original. Unless we know that the primary cause has been corrected and unless we remove a part of the bone which formed the construction. Though, at the same time, I believe with Hajek from my limited experience that more do appear than recur. Hence I make it a rule to say to the patient, "Now I do not see any more polyps," and not, that they are all out; and assure him that I have restored nasal respiration, but that some perseverance in possible subsequent operations may be necessary and that we can reasonably expect a final cure in most cases.

#### TREATMENT.

The more modern method of treating polyps shows that considerable advance has been made on the earlier methods. When an effort was made to remove them by internal medication, or when a punch or forceps was introduced almost blindly, and practically any tissue grasped and taken away that happened to come within the scope of the instrument, which we know often included a great deal of normal tissue, i. e. mucous membrane, portions of bone belonging to the middle turbinate, uncinatè process, etc., frequently causing profuse and dangerous hemorrhage.

The harm which may come from such faulty technique is,

1st. *Hemorrhage.*

2nd. *Atrophy* of the nasal chambers from the removal of

the normal mucous secreting tissue, which was replaced by connective tissue.

3rd. *Widening* of the nasal chambers which allows too much air to rush through the nose, drying the surrounding mucous membrane.

4th. *Snipping* off the polyp leaving the base in place, which means another polyp practically started.

Because of a more thorough knowledge and consideration of the anatomy of the parts, the procedure of treatment is now very interesting, scientific and effectual. Since the treatment is purely a *mechanical* one, it is not expected that internal medication is going to overcome this growth any more than it does similar growth of any variety and in any other part of the body.

1st. *Hemorrhage* is not feared, because polypoid tissue does not bleed very profusely, and the normal tissue which formerly produced the bleeding is not molested. This together with the present method of removal seldom results in profuse bleeding, and usually very little. Inquiry into the history for *hemafilia* should always be made and if found such a patient can safely be operated after a week of prophylactic treatment with Calc. Lactate 10 grs. t. i. d.

2nd. We no longer have *Atrophy* following this operation, because we do not sacrifice normal tissue, the removal of which was the direct cause of atrophy.

3rd. With the removal of the polypoid tissue only, we do not get so great an *enlargement* of the nasal cavities, as to cause a subsequent dryness of the nose. Nor is any of the secreting tissue replaced by connective tissue.

4th. Since we now *included* the *base* with the removal by the traction method recurrence from that source is reduced to a minimum.

I will not tax you with a description of the operative technique, because this forms a separate chapter in itself.

## SURGICAL ASPECTS OF "CHRONIC DYSPEPSIA" AND "ACUTE INDIGESTION."

A. R. GRANT, M. D., UTICA, N. Y.

(Read before the Interstate Medical Society of New York and Pennsylvania.)

THIS paper deals briefly with the management and healing of those patients who apply to the physician or surgeon because they suffer either from "chronic dyspepsia" or from "acute indigestion."

The subject of diagnosis is the most important feature of such a discussion for it is a fact that many, many of "these patients have had hundreds of dollars' worth of treatment and not ten dollars worth of diagnosis." (Bloodgood.)

First of all, it is the writer's opinion that the attitude of the profession should be, *that all diseases of the abdomen are surgical* until they can be proven medical.

In a typical chronic indigestion the patient must first of all be examined as to his personal history from birth, for such a careful anamnesis, repeated on at least one occasion, will usually establish the period of life when he began to be conscious that there was such an organ as the stomach: lesions of the upper abdominal organs leading to structural changes in those organs, regularly begin so gradually, and their symptoms are so mild, that the patient may never realize that his digestion is not as normal as anyone's. Remember that the anamnesis is the first and greatest factor in the problem of diagnosis.

Having determined that a case is at least subacute, our course is one of system. First, examination of the skin; eyes, ears, nose, throat and oesophagus, heart, compensation and relative blood pressure, lungs, kidneys, microscopic and chemical tests for structural changes and for function, pelvic and genito-urinary organs, rectum and examination of the faeces. A blood examination including a Wassermann or the Noguchi modification, for the evidences of syphilis is often important in fixing the diagnosis. Tests for tubercular diseases and such constitutional diseases as purinaemia and gout.

Lastly before the stomach is interrogated, the nervous system is *very* carefully examined and no phase of the subject is so hard to set forth clearly, because in so many of



these patients, when you have been over them in the manner just outlined you find not one single objective physical sign; the patient's ill feelings in the epigastrium being the only thing he wants cured and the only thing you have to treat, and it requires keen observation of the nervous manners and mental activities to eliminate the hysterical patient and the hypochondriac, whose indigestion is one symptom only of a multitude of complaints. Assuming that our patient is negative to the physical examination outlined above, and that we can eliminate at least exaggerated nervous diseases, we come to an examination of the abdomen and especially the stomach, gall bladder and appendix.

#### *Stomach:*

Anamnesis, first and most important factor in diagnosis.

So far as structural changes in the stomach itself are concerned the surgeon is mainly solicitous about the question, "Does the stomach empty itself in the approximately normal time of 75 to 90 minutes?" This is the best working formula of diagnosis for this organ is mainly a reservoir for food and drink and its principal office is feeding its contents to the intestines for digestion and absorption.

The ability to "drain" freely into the duodenum is determined first by the "Mayo meal" of a few raisins and a little half cooked rice fed at the evening meal, the stomach contents being examined next morning for retained portions, and secondly by Roentgenoscopy of a bismuth mixture at intervals up to ten hours. These two tests in conjunction with palpation of the stomach and duodenum for tumor are the principal and practical objective symptoms of ulcer and cancer of the stomach.

The writer is not oblivious to methods of chemical and microscopical examination of a test meal and of the possibilities of gastroscopy and fluoroscopy in doubtful cases, but the three practical tests as outlined above when positive, warrant an exploratory incision *after* rest and diet, and later exercise and diet fail to prevent the recurrence of the subjective symptoms of distress that occur about 3 hours and 20 minutes after eating, continued flatulency, "hunger pain" and gastric tenderness.

#### *The Gall Bladder:*

Anamnesis, first and most important factor in diagnosis.

The so-called "Catarrhal jaundice" of youth is an import-

ant factor in the history for it is my experience and belief that cholecystitis and cholelithiasis really begin in early life in this manner.

"Symptoms of chronic long continued and recurring indigestion are of the utmost importance and are commonly misinterpreted." (A. O. J. Kelley). Such a history should point clearly to an infected gall bladder even in the absence of the typical symptoms of attacks of gallstone colic. Appendiceal dyspepsia is very common and in conjunction with adhesions in the abdomen and pelvis furnishes a large proportion of the causes of "chronic dyspepsia" and their crises furnish the gravest forms of so called "Acute Indigestion."

All clinicians to-day agree that acute and chronic appendicitis when operated early, is almost free from mortality, and all appreciate the criticism attached to either a tardy diagnosis or to delayed surgical interference.

Ulcer may or may not perforate but cancer is regularly superimposed upon an older ulcer base and to get the early curable, operable cancer of the stomach, we practically must get its antecedent, the ulcer.

Infected gall bladders with gall stones may exist from about the age of adolescence throughout quite a long life, and because of a comparative infrequency of fatal crises these patients have been subjected to a host of remedies, useless so far as cure is concerned.

While such gall bladder patients may live many years, I am satisfied that their lives are shortened, their health precarious and their activities and usefulness very greatly curtailed.

#### *Conclusions:*

"The easier the diagnosis the worse the prognosis." (Bloodgood.)

Chronic long continued dyspepsia that recurs after a course of diet and remedies is usually caused by structural changes that prevent drainage of the stomach and is curable, surgically, with almost no mortality, except in neglected, advanced cases.

Acute indigestions or abdominal crises are warning signs of complications and should be considered as surgical conditions until proven to be functional and medical.

"All diseases of the abdomen are surgical until they can be proven medical."

**A CASE OF CANCER OF THE STOMACH.**

BY

H. H. READ, M. D., HALIFAX, CANADA.

ON Monday, June 30th of this year, I was called to make an autopsy in the case of an old gentleman of eighty-three, who had been my patient for over thirty years.

The stomach had been the seat of trouble, and I removed it from an inch below the pylorus to as far upwards as I could reach. The pylorus was practically closed, and with the stomach walls, was infiltrated with carcinomatous tissue, a half inch thick extending upwards about four inches, and above that the inner surface of the greatly shrunken viscus was deeply furrowed by red ridges which curved upwards to the severed line above. The adjacent organs had not been invaded and he had simply starved to death. His previous history was as follows:

Exactly twenty years ago he had come to my office complaining that every meal was vomited shortly after its ingestion; that symptom calling for phos. I gave it in the 6th cent. potency and his trouble passed away. He was then a short, squarely built man with a very ruddy complexion and his work was out of doors.

The following year he appeared again stating that his trouble had returned but now the vomiting was accompanied by pain, and now also his face was bleached. I prescribed the same remedy, but now it was of no avail, and presently I was summoned to his home where I found him in bed reduced to a skeleton and with a large basin by his side. He said that his appetite was good and his food rested quietly for two hours or more, but when it tried to leave the stomach "it could not pass," and pain began, culminating in agony which ended only when strong vomiting followed this, and ended in complete exhaustion.

The condition was obvious and the symptoms called for but one remedy,—baryta carb. which was administered in the sixth cent. potency.

I may remark that about this time an old school practitioner had been surreptitiously introduced and he gave the patient but two months to live. In a surprisingly short time



the vomiting ceased, in due time his skeleton became clothed again with flesh, and he returned to his occupation which was an arduous and responsible one. He continued to discharge his duties there until he was superannuated and retired on a pension. His ruddy complexion returned completely, and his strength may be inferred from the facts that on the 17th of May last he walked over four miles, and on the first Sunday in June, four weeks before his death, he walked as usual to his church and back again, fully a mile each way.

During the long period of eighteen and a half years, he suffered at intervals from attacks of painful vomiting, but these were overcome by the indicated remedies. It does look as if the remedy demanded by the depised law of cure might meet the needs of the patient sick with organic disease almost, if not quite, as well as the most dexterous surgeon's most brilliantly flashing knife.

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#### **TRANSIENT HEMIPLEGIA RESULTING FROM ACUTE ALCOHOLISM IN A CHILD.**

BY

CHARLES D. FOX, M. D., PHILADELPHIA.

THE following case is reported because it is so unusual. In fact, I have not been able to find any references to acute alcoholism, per se, as a cause of transient hemiplegia.

Carrie S., aet. 9 years, was brought to the Children's Homoeopathic Hospital in the police patrol, June 8, 1913. The following history was obtained: She had been perfectly well until the day of admission when, on awakening in the morning, she had felt weak and nauseated. After vomiting profusely she lost consciousness and was seized with a general convulsion—the first she had ever experienced. The police, who brought her to the hospital in a comatose condition, suspected that alcohol had been given to her, though its odor was not apparent in her breath.

The physical examination, made the same day, was as follows: Patient still comatose; pupils equal, normal in size, and reacting well to light and accommodation; paralysis of the right internal and inferior recti muscles; left facial paraly-

sis of central type; complete flaccid left hemiplegia with the Babinski sign, ankle clonus, and absent patellar reflex on the same side. The following day consciousness had partially returned but absolute flaccid paralysis of the left upper extremity and almost complete flaccid paralysis of the left lower one persisted. The other abnormal physical signs had disappeared. The third day the patient was perfectly conscious, felt well, and not even a trace of paralysis remained.

In the absence of any evidence of traumatism, or of uraemia, naturally it was thought, at first, that the little patient had had cerebral haemorrhage, so that the outcome of the case was quite surprising. After recovery had occurred, it was discovered that the father, while intoxicated, had given the patient half a drinking glass of whisky during the night before her illness. Consequently the child was detained in the hospital until the social service worker had completely investigated the case and materially improved home conditions.

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THE INFLUENCE OF THE OVARY AS AN ORGAN OF INTERNAL SECRETION. Graves( Boston) says: From the present status of our knowledge concerning the physiology of the ovary we seem justified in drawing the following conclusions:

Anatomical evidence makes it probable but not incontestable that the ovary is an organ of internal secretion. Infantilism is not a result of ovarian deficiency but is a local or general manifestation of a hypoplastic constitution in which the ovary may or may not share incidentally. After sexual maturity the ovary exercises a trophic influence over the other internal and external genital organs. There is evidence to show that the ovaries preside over menstruation by an internal secretion which has a selective action on the endometrium: and that abnormal uterine bleeding may be due to a hypersecretion of the ovaries. This evidence is not incontestable. Transplantation of ovarian tissue has not yet proved to be of great practical value in the surgical treatment of gynecological patients. Castration of sexually mature women directly causes vasomotor symptoms typified by hot flashes in 80 per cent. of cases. Definite psychoneuroses are not directly caused by castration, but such symptoms if present are due to other causes that produce physical or mental pain or discomfort. Ovarian extract is invaluable in the treatment of the vasomotor disturbances following castration. Its value in other gynecological conditions is problematical.—*Amer. Jr. Obs.* Vol 57—649.

## EDITORIAL

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### THERAPEUTIC PROGRESS OF THE YEAR.

DURING the past year the newer therapeutic measures that have attracted the greatest attention on the part of the medical profession have been either chemical as physical agents, such as radium, hydrotherapy, etc., or laboratory products, such as the vaccines and serums of various types.

Probably the substance that has attracted the most general attention has been radium. It seems to have been proven that radium when properly applied to superficial growths, either benign or malignant, on the skin or mucous membrane, is capable of bringing about a destruction of the growth. Whether the destruction of cancerous growths of this nature by radium will result in a larger percentage of permanent cures than have been brought about by operative measures is yet a debated question and it is probable that it will require several years' experience with radium to reach a decisive conclusion.

Aside from its effects upon benign and malignant growths, radium has attained an almost miraculous reputation with the laity, and to a degree with the medical profession, for curing all manner of ills, but especially neuritis, arthritis, gout and arteriosclerosis. There seems to be no good reason for attributing such therapeutic powers to radium, and, personally we are inclined to believe that the cures that have taken place under its internal administration are largely psychic in character. A substance so expensive and so remarkable in its physical properties as radium, is well calculated to inspire the public mind with unbounded confidence in its power to cure disease and, hence, the difficulty in determining to what extent these cures are due to the actual physical properties of the substance used and to what extent to the mental effect upon the patient.

Vaccine therapy has attained quite as widespread a degree of popularity among the profession as radium has with the laity. Every disease of bacterial origin has been treated by its appropriate vaccine and the mass of information that is being gathered on this subject is already enormous. Despite these



facts, however, we find it exceedingly difficult to form any conclusive or satisfactory opinion as to the exact field of usefulness of this method of therapy. The beneficial effects of the vaccines in various forms of staphylococcic infection are quite evident, and we believe that it may be said that this method of combating staphylococcic infections has established for itself a permanent place in therapeutics. As a means of protection against typhoid fever, the typhoid vaccine has attained an increasing reputation during the past two years. Russell states that the incident of typhoid fever has been diminished seventy-five per cent. by the use of this vaccine. The duration of the immunity conferred seems to last from two to four years on an average. The vaccine treatment of fully developed cases of typhoid fever seems to have received but little commendation from the majority of observers who have had an opportunity to make use of it extensively. Certainly the results have not been sufficiently striking to warrant us in believing that it compares in effectiveness with the ordinary homœopathic treatment of this disease.

Blood serum has been given quite extensive use in the past year, and experience would seem to indicate that it acts almost as a specific in the control of bleeding in cases of *melena neonatorum* and hemophilia. Human serum or serum obtained from horses may be used and most observers agree that both are equally effective.

Travers cites a typical case of a boy aged five years who belonged to a family of bleeders and who had a persistent hemorrhage continuing for six days, resulting from a slight cut in the tongue. After all measures had failed to control the bleeding, eight ounces of blood were obtained from the father's arm. The blood was placed in an ice-box for ten hours and then 20 c.c. of the serum thus obtained were injected subcutaneously in the child's buttocks. Within twenty minutes a firm clot had formed on the tongue and the hemorrhage was controlled.

The literature on the treatment of syphilis by salvarsan has become enormous. Hundreds of thousands of injections of this substance have been given and certain facts in regard to its action can be clearly stated. In the first place, the original idea of Ehrlich that syphilis could be cured by a single injection of salvarsan has been conclusively disproven. In fact it is questionable whether repeated doses of

salvarsan are capable of bringing about a permanent cure in any large percentage of cases. Mercury is a necessary adjuvant of salvarsan in practically all cases and by far the most favorable results to-day are obtained by giving three or four intravenous injections of salvarsan combined with a thorough course of treatment by mercurial preparations. Quite a large percentage of cases thus treated remain free from symptoms and have a negative Wassermann after the lapse of one or two years.

Other chemo-therapeutic agents, especially the analine dyes, have been widely used experimentally during the past year, in the effort to find a cure for pneumonia and tuberculosis. Lewis has found that Trypan red has the power of penetrating to the center of tubercles and has combined it with iodine, thymol and other substances, with the hope of destroying the tubercle bacilli. At present the method has not gotten beyond the experimental stage.

Cod liver oil has gradually lost its place in the treatment of tuberculosis, but we should not lose sight of the fact that in many cases it is valuable as a means of improving tissue nutrition.

A great deal of attention has been given to the study of digitalis during the past year and, with the new methods of investigating the function and condition of the heart muscle, brought out by MacKenzie, we have been given a much clearer understanding of the indications and manner of action of this valuable cardiac remedy.

Probably the most lamentable therapeutic failure of the year has been the much-lauded "Friedmann cure" for tuberculosis. The attempt to commercialize this purely experimental therapeutic procedure has resulted in discredit to Dr. Friedmann and to all associated with him.

G. H. W.

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### THE PROBLEM OF THE UNLICENSED "DRUGLESS HEALER."

HAS our own school of medicine, as one of the branches of the medical army that is trying to treat the sick and to eradicate disease, accepted its complete duty towards ridding the country of those who could properly be called dangerous "quacks"?

Has it been sufficiently alert and aggressive in using all of

its own power and influence towards the eradication of these evils?

I fear not. I assert and maintain that we have always been equally active and aggressive in guarding the highest ethical standards within our own ranks as has been the dominant school, but because we are a minority school, because the majority school, by reasons of numbers, vested rights and financial resources are better equipped to deal with these problems, our school has in an almost supine manner delegated to them the matter of their solution.

The unfortunate inference that might be taken from this attitude is that we as a school are indifferent as to the number and character of inadequately trained persons who may attempt to treat the sick, so long as our own standing and position is assured. This I know is far from the correct statement of affairs.

I think that in the past we have so often felt the wrong and injustice of the vested medical powers that we have delegated to the majority school the office of policeman to the profession. The concrete matter that brings this subject to my attention at this time is the fact that there are in the state of Pennsylvania at this time almost, if not quite, as many unlicensed persons who are treating the sick for a livelihood as there are members of our own school.

Startling, almost inconceivable, is it not? But I am not guessing in this matter. I have a list of unlicensed "drugless healers" who have formed a state association containing almost half as many members as we have in our own State Society, and I am credibly informed by those who have been investigating this matter in the field that this number does not represent a fifth of the unlicensed "healers" now practicing in this state.

An effort was made to group the unlicensed "drugless healers" into one organization, so that they could be dealt with as an entity. They first grouped themselves together into a state organization to which they gave the name of "Naturopaths," in which they attempted to collect, I was tempted to say corral, all of the non-licensed group. Unfortunately, into this group crept a natural born scamp, who proceeded to sell "Naturopathic" diplomas and to make such specious promises of the



favors that would be granted the "Naturopaths," that he rendered any attempt to negotiate with that group futile.

The request made of them that they formulate the complete list of unlicensed practitioners in this state resulted in the following rather formidable compilation: (1) The application of water to the body in diseased conditions either by application or direction: Hydro-Therapy, Kneip System, Burgess System, Priessnitz System, Just System, Helio-Therapy, Thermo-Therapy. (2) The use of food to effect the health of the body, as: All Prepared Foods, Selected Foods, Teas, Herb Treatments, Tropho-Therapy, Phyto-Therapy. (3) Methods affecting the mind and thus affecting the body, as: Suggestive Therapeutics, Magnetic Healing, Metaphysics, Vita-Therapy. (4) Local treatment to the spine, as: Chiropractic, Spondylo-Therapy, Nepravit, Chiropractic-Spondylo-Therapy, Neuropathy. (5) Any non-medicinal treatment to the body, as: Mechano-Therapy, Swedish Movements, Massage, Scientific Massage, Electro-Massage, Vibro-Massage, Medical Gymnastics, Physical Culture, Neurology, Oxypathy.

The above is a literal transcript and classification of the unlicensed practitioners in this state as submitted to the Bureau of Medical Education and Licensure by their own representatives. Thirty odd varieties; but that was last summer, and we have since that learned of several new "pathies" and "ologies."

The real problems that must be considered out of this complex are, first, how shall the practice of any or all of these mysterious specialties be so regulated that the public may be safeguarded against imposters, and assured that those that they call to their aid in sickness are reasonably safe advisers, and, second, have any of this group any real contribution to make towards healing the sick that is worthy of serious consideration or of preservation?

The only solution the Bureau can see, the only solution that the better representatives of this group of unlicensed practitioners can suggest is that the Bureau sets a special standard for this group and strictly limits them in the method of their practice. This suggestion follows in many respects the new law of California, which sets forth with specific detail the hours of study in the various subjects that a qualified M. D. must take, and with equal detail and directness sets a separate

standard, with subjects and hours of study that the qualified "Drugless Healer" must take.

The Mechano-Therapeutist does seem to have a real contribution to the help of the sick. Some of the graduates of the Swedish Movement cure seem to have had a training in their specialty as severe and complete as the most exacting could desire. I do not think that it would be wise on our part to repeat the blunders the old school made a century ago and use all the drastic methods that vested power makes possible. I feel that the most wise and judicious method of dealing with the present rather acute condition is to insist and enforce an adequate training in fundamentals, then after the standardization has been created to use all the drastic power the law gives us to drive out of practice those that cannot qualify.

The recent higher standards in medical education and in medical colleges has helped to drive out of the study of medicine a large number of young men who might have otherwise entered a medical college easier of access and graduation, and there is an ever-increasing number entering these "drugless" institutions. We have in Pennsylvania to-day at least five so-called colleges that are giving diplomas to treat the sick along "drugless" lines, and not one of their graduates is legally eligible to practice. It is certainly a condition and not a theory that confronts us, a condition that cannot be solved by academic theorizing, a condition that we should attempt to solve in a manner tending towards its permanent solution.

The ordinary practitioner of medicine, safe and secure in his own position of the legal right to treat the sick does not give much concern or attention to the great unlicensed group unless one of that number treads upon his own professional toes; yet there are a large number of that unlicensed group who are earning a better living at treating the sick than he is himself. I do not want to make the appeal on the commercial basis, upon the financial loss that comes to legal practitioners of medicine because the unlicensed group are treating so many patients that should be under his care; but I want to strike the higher ethical note that our sacred calling should be more adequately protected from imposters and that our own school must assume its full share in this work.

D. P. MADDUX.

**APPEAL TO ALL FRIENDS AND ADHERENTS OF HOMŒOPATHY.**

THE undersigned is engaged in writing and publishing a most complete and extensive biography of the founder of Homœopathy, Samuel Hahnemann. The work has advanced so far, that the publication can be assured within one year.

In order to be sure of not missing anything of value, all owners of original letters or other documents, pictures, medals, etc., of Hahnemann or his immediate disciples are requested to send them to the undersigned (which should be sent by registered post). After taking copies or photographs they will be returned immediately in perfect condition, also by registered post.

Full acknowledgment will be made in the work for all loans. The material I have already collected is far more complete than anything before attempted, including hundreds of original letters and legal documents of Hahnemann.

DR. RICHARD HAEHL.

Stuttgart (Germany), Helfferichstr 10.

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**BUREAU OF MEDICAL EDUCATION AND LICENSURE OF THE STATE OF PENNSYLVANIA. EXAMINATION QUESTIONS---DECEMBER, 1913.***First Session.—Physiology, Pathology, and Bacteriology.*

1. In acute lobal pneumonia, describe the local lesion and the disturbed functions.
2. Name two heart lesions that might result in broken compensation and show how the normal functions of the heart would be disturbed.
3. Describe two lesions—one of the gall bladder, and one of the liver—that will cause lessening of the supply of bile to the duodenum. Describe the effect of this loss on digestion assimilation.
4. Describe the lesions, name the usual causes and give the laboratory technique for demonstrating the varieties of urethritis.
5. In carcinoma of the female breast, describe the gross and the microscopical appearance of a common variety and give the usual points of metastasis.
6. In examining a specimen of urine from a pregnant woman, state the findings that would suggest oncoming uremic convulsions.
7. Given a case of malaria, describe the lesions and detail the laboratory tests for making the diagnosis positive.
8. Describe the lesion in tabes dorsalis, (locomotor ataxia) and show how the functions of the cord are disturbed.
9. Given a case of meningitis, give your technique for demonstrating



the determining cause by means of lumbar puncture. Discuss the disturbance of function that would result from such a case.

10. Given a suspected case of typhoid fever: by laboratory tests differentiate the case from septic infection.

*Second Session.—Diagnosis, Symptomatology, Medical Jurisprudence and Toxicology.*

1. Describe the symptoms and course of chorea.

2. Enumerate the symptoms of varicella. Name a disease with which it may be confused and differentiate them.

3. Enumerate the symptoms and physical signs diagnostic of pleurisy with effusion.

4. Enumerate the diagnostic symptoms of chronic eczema, and differentiate it from scabies.

5. What is pyemia? How is it characterized clinically? enumerating the general symptoms.

6. Enumerate the symptoms of tubercular joint disease, and differentiate it from acute articular rheumatism.

7. Give the etiology of, and enumerate the symptoms of acute nephritis. Name four toxic drugs that may produce it.

8. Describe in detail symptoms of strychnine poison, and differentiate it from uremic convulsions.

9. How would you differentiate a case of severe ptomaine poisoning from the conditions produced by arsenical poisoning?

10. As a witness in court, what would be your evidence in substantiating the fact of a death by drowning?

*Third Session.—Gynecology and Obstetrics, Physiological Chemistry.*

1. Given a pregnant woman, of seven months or more, stricken suddenly with severe hemorrhage, what would be your deductions? Outline the management of the case.

2. State pelvic measurements or other conditions that would warrant an interference with the natural progress of gestation or of labor; what procedure would you recommend in each condition noted.

3. Enumerate the conditions that must be considered in excessive or protracted bleeding in a non-pregnant woman: outline surgical operations or methods that may be required, with the reason for selecting each. (Omit details of operation.)

4. If at the third month, a primipera should engage you to care for her through the period of gestation and labor, give in detail your care of the case, including measurements and tests.

5. What injuries may result to the birth canal from labor? Give in detail the management of a case of normal labor, with a view of preventing such injuries.

6. What is the significance of sudden collapse and shock that might develop during labor? Outline your treatment for such a case. (Omit description of operation.)

7. What breast complications may follow confinement? Outline the

care of the breast that would probably prevent such complications. If they should occur, how would you treat them?

8. Indicate the steps in the digestion and absorption of the food substances present in a ham sandwich.

9. Discuss the chemistry of intestinal fermentation and putrefaction.

10. How may blood be detected in the feces, and what is the significance of this finding?

*Fourth Session.—Surgery and Anatomy.*

1. Enumerate the constitutional and local conditions that may cause delayed or non-union of bone after a fracture: State two surgical procedures for its correction.

2. Outline the methods of examination by which you would determine the existence of a fracture at the surgical neck of the humerus: what is the usual deformity in this fracture? What is the anatomical explanation?

3. Enumerate the EARLY symptoms that are caused by a typhoid perforation. Outline a surgical operation for the same.

4. State the usual anatomical avenues by which infection reaches the mastoid process. Outline a surgical operation for mastoid abscess.

5. What anatomical structures may be involved in the extension of a bunion? Describe its surgical treatment.

6. Name the varieties of club-foot: outline a surgical operation for the correction of any one form, with the anatomical and mechanical reasons for employment of same.

7. In fracture of both bones at the forearm, the actions of what muscles should be specially considered? What character of splints should be applied?

8. Enumerate symptoms and conditions upon which might be based the diagnosis of a malignant growth of the breast: outline a suitable surgical operation, giving the surgical anatomy of parts.

9. What is the usual position of the fragments in fracture of the patella? What is the anatomical explanation? State, without details of technique, two methods of treatment.

10. Outline two methods of treating carbuncle—give reasons for employment of each.

*Fifth Session.—Practice and Materia Medica and Therapeutics, Hygiene and Preventive Medicine.*

1. State the sanitary precautions to be observed in the treatment of scarlatina. What are its possible dangers? Give indications of three remedies that might be used in its treatment.

2. (a) Describe the technique of general anæsthesia. (b) Give reasons for the choice of each one of three agents used for this purpose.

3. Give the management and treatment of a well developed case of follicular tonsillitis.

4. Outline the most important factors in the treatment of a case of incipient tuberculosis.

5. Outline the therapeutic action of (a) santonin, (cina, Homœopathic) (b) camphor, (c) cimicifuga, (d) aconite, (e) ergot.

6. Outline the general medical treatment in exophthalmic goitre. What symptoms, in your opinion, would indicate the need of surgical intervention?

7. Given a case of typhoid fever with hemorrhage, outline the management during the first period of the hemorrhage and post-hemorrhagic stage and state the therapeutic action of each drug used.

8. In the treatment of chronic interstitial nephritis, what dietetic and hygienic suggestions would you make? Name three drugs that might be employed in the treatment of this condition, with the precise reason for the employment of each.

9. What are the main objects accomplished by the scientific ventilation of a school building? What degree of temperature is most conducive to health and mental activity in such buildings?

10. What are the main dangers to be apprehended in raw milk as ordinarily found in the market? What measures should be adopted in minimizing such dangers?

CURRENT OPINIONS CONCERNING THE TOXEMIA OF PREGNANCY.—Pfeifer summarizes his admirable article by saying that pregnancy in many cases is not physiological and in all cases is so close to pathological that slight additions make it frankly so; further, the profession and laity are slowly coming to this view. There will be few cases of severe toxæmia if we pay closer attention to the minor ills of pregnancy and regard them as possibilities of future trouble. While the various types of toxæmias are probably phases of one disease, no one definite etiology obtains in all cases. A predisposing cause being admitted, the pathogenesis of the toxæmia cannot be stated with accuracy at the present time, beyond the unsatisfactory term "disturbed metabolism." Usually the types are found to conform to one of two forms, hepatic or nephritic, with the former often causing the latter. The urine systematically examined in toxæmia for nitrogen partition where possible, as well as albumin, acetone and diacetic acid will aid in diagnosis and treatment in the early cases and possibly the later stages as well. Blood pressure examination is of value in all stages of toxæmia, especially that of the later months, and should be taken as often as the patient is seen. No rise can be regarded lightly and may be the first sign of trouble. The few serious cases in which pressure is low must be considered exceptional and do not negative the value of the test. The leukocyte count shows the resistance of the patient and the progress of the disease. Eye signs furnish an urgent indication for terminating pregnancy, if seen early. In treating the actual convulsive seizure, the sooner the uterus is emptied after the first convulsion, avoiding accouchement force, the better the prognosis for mother and child. When the attendant is not capable of major surgery and the surroundings incompatible with clean work, conservative treatment (perhaps Stroganoff's method) will be wisest. Venesection in advance of delivery may not always be wise as the additional blood lost in operative procedures plus the shock of the operation may prove too great. Venesection, no matter what the character or rate of the pulse, as proposed by one writer, seems unjustifiable.—*Amer. Jr. Obs.* Vol. 67—1088.



## GLEANINGS

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WHY INCIDENTAL REMOVAL OF THE VERMIFORM APPENDIX, WHEN REASONABLY POSSIBLE, SHOULD BE THE RULE, is the title of an article by Goldspohn (Chicago). Unfortunately, the author has displayed a certain amount of irritability and impatience with those who have not yet become ready to accept this as a rule, particularly as a rule which has not many exceptions. He says there still remain many who object to it on sentimental and theoretical grounds, that, in some instances appear as rather shabby excuses—which is not “nice” as the French would say.

However, the main reasons assigned by the author are the following: The vermiform appendix is a vestigial structure, not to be regarded as an organ or in any sense essential to the body. The appendix is the *locus minoris resistantiae* of the entire intestinal tract, if not of the entire alimentary canal. Extensive clinical experience and careful microscopical examination of large numbers of appendices prove that this most vulnerable member very frequently seriously disturbs the functions of the stomach, duodenum and the gall-bladder; and experiments on animals show that it can be the primary cause of ulcers in the former. Chronic appendicitis so often masquerades as disease of the gall-bladder that many of the best surgeons were misled thereby to do operations on the gall-bladder which did the patients no good unless the appendix was removed at the same time. Surgeons have repeatedly wiped out cases of persistent stomach disorder, that had often been treated as ulcer. Moynihan has emphasized appendiceal dyspepsia and says it resembles the symptoms of ulcer of the stomach.

Another reason for its incidental removal is that the appendix is too treacherous to be trusted when it appears normal. About contraindications, the author says of course there is a limit to this prophylaxis of incidental removal. Some patients are taxed to the utmost by the severity of the main operation or because they are in bad condition. In cases of badly soiled or infectious fields of operation, the appendix may lie separate in surroundings that should not be invaded from such a field unless the appendix has given evidence of present disease. Further contraindications are found in operations for carcinoma and tubercular disease, in cases over fifty years of age.—*Amer. Jr. Obs.*, Vol. 67—481.

THEODORE J. GRAMM, M. D.

THE TOXICITY OF FREE BLOOD IN THE ABDOMEN.—Bröse says that free blood in the abdominal cavity must be regarded as dead tissue. Even though it remain aseptic, the products of its disintegration are toxic to the organism. Even from small amounts of blood serious conditions, resembling collapse, may develop. Even if primary collapse is absent, intestinal

paralysis often occurs. Temperature elevation is rarely absent and somnolence is common. It has not yet been possible to determine the chemical character of the poison developed. The clinical manifestations indicate the advisability of removing as much of the blood as possible at the operation for ectopic pregnancy. We should also remember that the oozing of blood after other abdominal operations may induce toxic conditions. Puncture of the posterior vaginal vault would clear up such a condition.—*Abstr. Zentralbl. f. Gyn.* 1912—1770

THEODORE J. GRAMM, M. D.

**RUBBER GLOVES AND WOUND INFECTION.**—Hellendall and Fromme (Dusseldorf) have made a study of the secretion collecting in the rubber gloves used during operation for the purpose of determining its relation to wound infection. Their results have shown that a secretion collects in rubber gloves even when they are put on dry. This fluid contains a large number of germs even though the hands were carefully disinfected with hot water and alcohol and the gloves were sterilized. Consequently the holes in the gloves, even when put on dry, are no less dangerous than those in gloves put on while wet. Even the smallest holes constitute a flaw in the asepsis as tending to direct wound infection. There is also danger of the operator becoming infected. The maintenance of dryness of the hands and germ arrest from the use of 70 per cent. alcohol are therefore doubtful. If sublimate be added to the hot water-alcohol method and the gloves be used dry, the glove fluid becomes less dangerous; hence the recommendation to use the extended Furbinger method—cotton gloves to protect the rubber, and attention should be given to the smallest holes, especially in those who perspire easily and have much fluid collect in their gloves. They should also frequently rinse, dry their hands and put on another pair of gloves.—*Zentralbl. f. Gyn.* 1912—1601.

THEODORE J. GRAMM, M. D.

**CANCER OF THE UTERUS AND ITS EARLY DIAGNOSIS.**—Kamperman (Ann Arbor, Michigan) has based his article on this subject upon a study of two hundred and twelve cases. The disease occurs in two distinct clinical varieties, and they differ so greatly in prognosis and in treatment that the distinction should always be borne in mind. Of the two, cancer of the cervix occurs in about 83 per cent., while in the fundus it is encountered in about 16 per cent. of cases. One form which unfortunately does not cause enough symptoms to alarm the patient and is often overlooked, shows hard, thickened, indurated, friable cervix without much destruction of tissue. This represents the earliest form of the disease. Another form is the proliferating variety, where the cancer juts out from the cervix and extends into the vagina, which it may entirely fill. This is called the cauliflower growth. The third clinical form presents an excavated cervix, with marked destruction of tissue. Many of the cauliflower growths at a later stage, show this crater form. In carcinoma of the fundus a fungous growth replaces the endometrium which may involve the entire endometrium. Occasionally the fungous growth is only polypoid. In the corpus uteri the form is adenocarcinoma. In the cervix the varieties are adenocarcinoma, rather rare and extremely malignant, and the squa-

mous celled carcinoma. In certain cases the disease arises from the deeper or basal cells and is then called basal celled carcinoma. The author has found that adenocarcinoma develops through a longer range of years than cancer of the cervix. The number of these cases is distributed quite evenly between thirty-five and sixty-five years of age. The percentage of nuliporous patients is also larger than those affected in the cervix. From this it may be assumed that child-bearing does not stand in such close relationship to the fundal disease as it does to that of the cervix. The majority of cases of carcinoma of the uterus are inoperable when applying for relief. The operability depends upon the extent of involvement. After symptoms have existed for a year or two the case is usually beyond surgical relief. At first the normal menstrual discharge is prolonged; later it is continuous. An intermenstrual discharge appears early in the disease. Pain is a late symptom. The disease may exist for a much longer time in the fundus than in the cervix, without producing symptoms. Cachexia only occurs late in the disease. The author is quite hopeful of a cure from early operation. Among other facts which the author has emphasized is that during the last five years the death rate from cancer has increased 15 per cent. in Michigan.—*Amer. Jr. Obs.*, Vol. 66—596.

THEODORE J. GRAMM, M. D.

DEPARTMENT OF AGRICULTURE ADVISES THAT MILK BE PASTEURIZED AT LOW TEMPERATURES.—In order to determine the best way of Pasteurizing milk so as to kill the disease germs and yet not give the milk a cooked flavor or lessen its nutritive value, the Department of Agriculture, through its Dairy Division, has been conducting a series of experiments, treating milk at different temperatures and for different lengths of time. According to the report on these experiments in Bulletin 166 of the Bureau of Animal Industry, when milk is Pasteurized at 145° F. for thirty minutes the chemical changes are so slight that it is unlikely that the protein (muscle-building element) or the phosphates of lime and magnesia are rendered less digestible than they are in raw milk.

Moreover, from the bacteriologic standpoint, Pasteurizing at low temperatures is found to be more satisfactory than Pasteurizing at high temperatures. According to Bulletins 126 and 161, where low temperatures are used, the majority of bacteria that survive are lactic acid organisms, which play an important part in the normal souring of milk. When milk is efficiently Pasteurized at high temperatures, the bacteria which survive are largely of the putrefactive kinds, and milk so treated if kept for any length of time has a tendency to rot instead of sour. From the standpoint of economy, the technologist of the Dairy Division finds that Pasteurizing at low temperatures calls for less heat. It is found that it takes about 23½ per cent. less heat to raise milk to the temperature of 145° F. than to a temperature of 165° F. A similar gain is a saving of the ice needed, because it will require 23½ per cent. more refrigeration to cool milk to the shipping point when it is Pasteurized at the higher temperature. The Department, therefore, recommends that "when market milk is Pasteurized it should be heated to about 145° F. and held at that temperature for thirty minutes."—*Archives of Paediatrics*, September, 1913.



## Monthly Retrospect

### OF HOMOEOPATHIC MATERIA MEDICA AND THERAPEUTICS

CONDUCTED BY DR. DONALD MACFARLAN  
PHILADELPHIA

**PHOSPHORUS IN RETINITIS.**—In a recent issue of the *North American Journal of Homœopathy*, Dr. H. D. Schenck, of Brooklyn, N. Y., gives the result of treatment of an interesting case of retinitis. This was read before the Homœopathic Medical Society of the County of Kings, New York.

In 1904 at a meeting of the O. O. & L. Society Dr. Schenck reported the use of phosphorus in central retinitis in an otherwise healthy man of 39. He had noticed after a ride in the sun that there was a cloud like "dust" before his left eye, and that the perpendicular lines of objects had rather sharp curves inward at several points and the horizontal lines curled downwards at the ends. He had some fatigue of the eyes, slight photophobia and occasional pain in the temples which was more fatigue of the head than actual pain. The external conditions and the right fundus were normal. In the left macular region there was a square spot of opaque retinal tissue with a few dots and dashes extending into the retina, elsewhere the left retina and optic disk were normal. O.D.—6-6 O. S.—6-12 with difficulty. O.S. with a plus Dc. Ax 90 v.—6-12.

Phosphorus was used four times a day from May 21 to June 27, and saccharum lactis was given three times a day for ten days, followed by phosphorus three times a day for a week. Nothing but saccharum lactis was given after July 17.

The symptoms in this case were the poorly defined central scotoma which later became a thin central veil which he called "dust" and the curves in the perpendicular and horizontal lines. These disappeared in the reverse order in which they originally appeared.

In this case the subjective symptoms upon which the prescriptions were based were: First, dust before the eyes; second, fatigue of the eyes and head even without much use of the eyes.

**DIAGNOSIS OF TUBERCULOSIS IN YOUNG CHILDREN.**—Dr. Eric Pritchard, *The Practitioner*, says, in part, that the absence of constitutional and focalizing symptoms makes the diagnosis of tuberculosis difficult. Thus infants may be literally riddled with tubercles and older children have extreme involvement of the mediastinal or peritoneal glands without the exhibition of any serious impairment of health or constitutional symptoms. Wasting is by no means an essential factor until the disease is very far advanced, although infants, as a rule, come to a standstill and fail to put on weight no matter how careful their dietary is arranged. The tempera-

ture charts show irregularities, but seldom those great fluctuations, characteristic of the tuberculous process in adults. In all suspected cases, the temperature should be recorded for as long a period as possible and at varying times of the day. Sweating is a common symptom but it is of so many childish complaints, therefore little reliance can be placed on such evidence. Speaking generally the older the child the greater the significance of sweating as a diagnostic point in favor of tuberculosis. A child twelve years of age who regularly suffers from profuse perspiration at night, with beads of cold sweat showing on the face and forehead is probably actually tuberculous, or at least a candidate for tuberculosis. General lassitude, poor appetite in the morning, and buoyancy of spirits alternating with periods of depression are all in favor of tuberculosis. The one infallible proof of tuberculosis is the discovery of the bacillus in the sputum, in the emunctories, in the discharge from wounds, or in the cerebro-spinal fluid of the different tests for diagnosis.

Pritchard says that during the first two years of life, when tuberculosis is rare and its consequences more serious, the tuberculin test, von Pirquet for instance, is most useful. Inasmuch as the constitutional symptoms of tuberculosis in children are by no means pathognomonic and inasmuch as the specific tests are not always available, it is to the lymphatic system that we must appeal for the clinical data on which to base a reliable diagnosis, for, as has already been pointed out, it is the lymphatic system which first bears the brunt of the attack and it is while confined to the lymphatic system that the disease offers the best opportunities. However, the constitutional symptoms of an early tuberculosis in childhood are neither pathognomonic nor severe, and from what has been already said with respect to the signs and symptoms of involvement of the lymphatic system, it will be readily understood that the diagnosis is extremely difficult in the majority of cases. With respect then to the diagnosis of tuberculous disease in children it may be stated generally that it must depend on a full consideration of the constitutional symptoms, of the evidence afforded by the specific tests and of the results of a careful examination of the lymphatic system. Although in early life, the gross diagnosis of a tuberculous affection is all important, in later childhood the mere diagnosis of the presence of tubercle is less important than a reliable estimation of the extent to which the tuberculous process is under the control of the natural resources for defence and the extent to which it is likely to gain a hold on the subject.—*American Medicine*.

SEPIA.—An interesting case bearing on this drug was that reported in a recent issue of the *Journal of the American Institute*, by Dr. Granow, of Frankfort, Germany. The salient points of this interesting case are the following:

Marie A., the wife of a brewer from Sachsenhausen, twenty-two years of age, consulted Dr. Granow June 27, 1906, on account of drawing pains and rumbling in the abdomen. She had sought relief from various sources but without success. People now were telling her that she had a tapeworm, and she was almost inclined to believe this. Now she had heard about Dr. Granow and had come to ask him to treat her, as she had heard that he had moved to Frankford at the request of the united Sick-

benefits. She was one of their patients. Dr. Granow, of course, wished to investigate her case. An examination of the stomach, the liver, the spleen, the kidneys and the bladder only gave negative results. The action of the bowels also was good, only the stool was frequently hard and difficult to evacuate. The patient has been married for a year and conjugal intercourse gives her great pain. Though very anxious to have children, she had not, as yet, conceived. It was very natural that the medical attendant should then examine the uterus, and he found here the confirmation of her symptoms and the cause of her troubles. The mouth of the womb had sunk down and was broad and hard, meeting the examining finger half way. The uterus was flexed backwards, lying on the rectum and thereby obstructing the passage of the contents of the bowels. Thence came the constipation. The cause would seem to be that when a girl of fifteen years of age she had fallen while carrying a heavy basket. The menses had always appeared in connection with violent cramp-like pains. Dr. Granow succeeded with some trouble in bringing the womb in an upright position. It was fortunate that in spite of the long reflex position it had not yet become attached to the rectum. He supported the uterus by a tampon secured in the cul-de-sac of Douglas, and gave the patient a bottle of *sepia* 5. He took the tampon away on the second day, the *sepia* being continued until July 5. And the success? The uterus has since then retained its normal position. The woman is happy and full of hope, attends to her work and is free from all pains, and her stool is normal.

Did *sepia* assist in this recovery? Dr. Granow fully believes so. Without this medicine the uterus would have returned to its former position on the rectum. This is the opinion of Dr. Granow. There can be no doubt of the value of this remedy in a host of conditions very frequently met in gynecologic practice. *Sepia* is a remarkable drug in bringing on the monthly courses in women, even when their absence has been noted for five or six months. It is of service, especially in left ovarian soreness (right ovary only slightly affected) and bearing-down uterine sensations. The remedy causes in the prover a marked catarrhal conjunctivitis.—By Dr. Granow, Frankfurt, A. M., in *Leipzig, pop. Z. f. Hom.*—*Hom. Recorder*.

**RHODODENDRON CHRYSANTHEMUM.**—Causes toothache and swollen gums. It effected an astonishing and immediate cure of neuralgia of the inferior and superior dental nerves. The woman in agony, sleeping only for short intervals for seven weeks; had sound molars removed and narcotics given by her regular physician without curative effect; often verified its curative powers in certain toothaches; it causes stiffness of the neck and stumps of teeth to be loosened.

**SULPHATE OF MORPHIA 6DEC.**—Given every hour for two weeks, produced on the third day violent pain through the eye-balls; dimness of sight; pupils not dilated, retina under-sensitive; had previously good sight but on taking the proving was unable to read; type became blurred, even when holding the reading matter at the usual proper distance. At usual distance there was blurring and indistinctness. Medicine caused the throat to become dry and parched. There was nausea present and a fullness in the forehead. The voice became husky.



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# THE HAHNEMANNIAN MONTHLY NEWS AND ADVERTISER

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**Oxford University Press—Bacteria.**—By Dr. Max Schottelius, with ten colored plates and 33 illustrations in the text. Second Edition. London, Henry Frowde: Oxford University Press, 35 W. 32nd St., New York.

The purpose of this volume is to convey to the student and practitioner of medicine a general knowledge of the nature of bacteria and their relation to disease. The author begins by devoting a chapter to the "Position of Bacteria in the Scheme of Nature and in Regard to the Other Forms of Life," in which he describes the relation of bacteria to fungi and other microscopic organisms. He then takes up the various methods of bacteriological research. Chapter III is devoted to "Methods of Disinfection," followed by a description of the process of Immunity and of Protective Inoculation. The bacteria concerned in the various infectious diseases are then described seriatim as are also the various protozoa that are of importance in the production of disease.

The style of the text is such as to render the book a very readable one and is entirely free from undue technicalities which so often detract from the interest of a book of this nature. Despite this fact it contains a great deal of valuable information in regard to a subject that is of growing importance to physicians and to the public in general. It is a work that can be highly commended to mothers and nurses.

**Oxford Medical Publications—X-Ray—Diagnosis and Treatment.—A Text-Book for Practitioners and Students.**—W. J. S. Bythell, B.A., Cantab., M. D., Vict. Hon. Physician to the Ancoats Hospital, Man-



chester, etc., and A. E. Barclay, M.D., Cantab., M. R. C. S., L. R. C. P. Medical Officer to the Electrical and X-Ray Departments of Manchester Royal Infirmary, etc. Henry Frowde: Oxford University Press, 35 W. 32nd St., New York.

The growing importance of the X-Ray in Medical and Surgical diagnosis and treatment, has created a demand for a work that shall give to the general practitioner such information in regard to the subject as will enable him to decide intelligently whether, in a given case, the X-Ray would be of any assistance from a diagnostic standpoint. The present work has been written for the purpose of supplying information along these lines for the general practitioner.

In it will be found also the sort of information that he is likely to need. A careful perusal of the work reveals the fact that the author has been very conservative in his statements as to the use and value of the X-Rays and has avoided the undue enthusiasm that has characterized the works of many authors.

After a description of the apparatus and tubes used in X-Ray work the author takes up a description of the examination of Bones and Joints, a Detection of Foreign Bodies, Examination of the Thorax, of the Abdomen, the Urinary System and concludes with a chapter on X-Ray Therapeutics and X-Ray technique. The book contains 118 illustrations, a study of which will give the physician an excellent idea of radiographic plates and will familiarize him with the methods of interpreting the shadows that are on the plates. It is an excellent and practical presentation of a very important subject.

**Oxford Medical Publications.**—Text-book for Nurses. Anatomy, Physiology, Surgery and Medicine, by E. W. Hey Groves, M.S., F.R.C.S., Assistant Surgeon, Bristol General Hospital, etc., and J. M. Fortescue-Brickdale, M.A., M.D., Assistant Physician Bristol Royal Infirmary, etc. Henry Frowde: Oxford University Press, 35 W. 32nd St., New York.

The purpose of this work is to provide for nurses a comprehensive text-book to supplement the lectures that are usually given by the members of the medical and surgical staff of their hospital and to serve as a basis to the examination papers by which their knowledge is to be tested. Its aim is to enable the nurses to understand the principles underlying medical and surgical treatment and no attempt has been made to present the technical details of actual nursing.

The first section of the work is devoted to anatomy and physiology; section two deals with subjects related to surgery such as bacteria, infectious wounds, anæsthesia, tumors, diseases of the genito urinary organs, etc. Section three is devoted to medicine and, under this heading are considered the specific infectious diseases, the respiratory, circulatory, digestive and urinary system, also diseases of the blood and general diseases. The work is printed in large type and the style of the text is simple and devoid of undue technicality. The authors have been very successful in including within its four hundred pages a concise and comprehensive summary of the various departments of medical knowledge. It is a work that will meet a long existing need in this department of medical training.

**Clinical Guide.**—By George Frederick Laidlaw, M.D., Professor of the Practice of Medicine, to the Flower Hospital, etc., etc. Compiled for use in Dr. Laidlaw's clinic in the New York Homœopathic Medical College and Flower Hospital. New York, Boericke & Runyon. Price, \$1.50.

Dr. Laidlaw's reputation as an eminently practical clinician is well sustained by the character of the "Clinical Guide" which was primarily compiled for use in his clinical laboratory and which he has now published for the benefit of the profession at large.

The work is intended, as its title indicates, to serve as a practical guide for the undergraduate, and the postgraduate in studying medical cases in the sick room and in the laboratory.

The first portion of the work is devoted to the subject of "Tuberculin," and the methods of preparing and employing this agent in diagnosis and in treatment have been carefully and critically reviewed.

The author next takes up the examination of urine, the gastric contents, the blood, sputum and then considers the laboratory diagnosis of typhoid fever and of syphilis.

Following these are chapters devoted to Diagnostic Punctures, Cyto-Diagnosis, Special Methods of Percussion and Auscultation, Test Diet for Diabetes, Case Histories, etc.

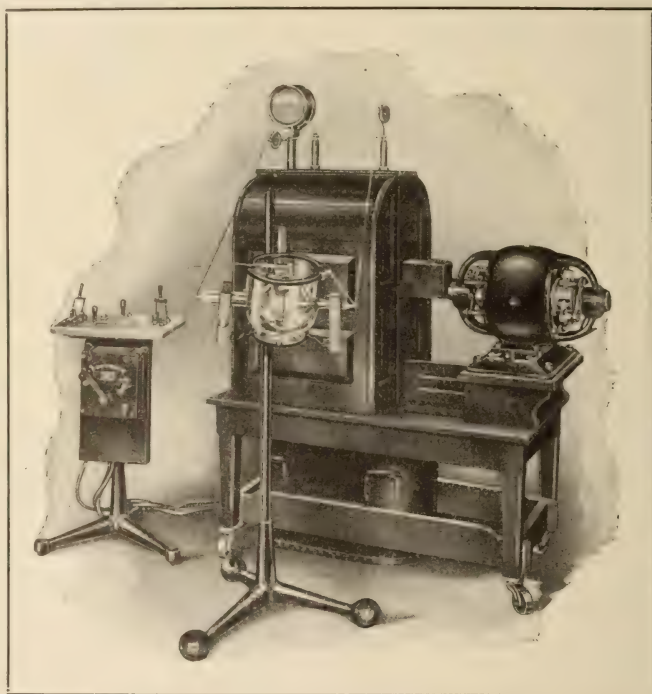
We congratulate Dr. Laidlaw most heartily on this valuable addition to medical literature. His work is practical, up-to-date and thoroughly scientific. It should meet an important need in the daily work of every student and practitioner of medicine.

**Progressive Medicine.**—A Quarterly Digest of Advances, Discoveries and Improvements in the Surgical and Medical Sciences Edited by Hobart Amory Hare, M.D., Professor of Therapeutics and Diagnosis in the Jefferson Medical College of Philadelphia, etc., etc. Assisted by Leighton F. Appleman, M.D., Instructor in Therapeutics, Jefferson Medical College, etc., etc. Volume IV, Dec. 1912, Diseases of the Digestive Tract and Allied Organs, the Liver, Pancreas and Peritoneum—Diseases of the Kidneys—Genito-Urinary Diseases—Surgery of the Extremities, Shock, Anæsthesia, Infections, Fractures and Dislocations and Tumors—Practical Therapeutic Referendum. Lea & Febiger, Philadelphia and New York. Price \$6.00 per year.

The two most important subjects from the standpoint of the general medical man perhaps that are included in this volume of Progressive Medicine are a review of "Diseases of the Digestive Tract and Allied Organs," by Edward H. Goodman and "A Practical Therapeutic Referendum," by Dr. H. M. Landis. Dr. Goodman's review of the recent advances in Diseases of the Digestive Tract and Allied Organs contains so many important subjects that it is difficult to present a comprehensive idea of it within our limited space. The portions dealing with "Analysis of Gastric Contents," and "Gastric Ulcer" are full of important and valuable hints. About eight pages are devoted to the important subject of cancer of the stomach and all of the latest diagnostic procedures that have been recommended in connection with this malady have been thoroughly and accurately considered. In his "Practical Therapeutic Referendum," Dr. Landis has presented a complete summary of all of the therapeutic advances of the past year and

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has made such comments and criticisms upon them as his reading and experience have deemed advisable. Any practitioner will find it well worth while to carefully peruse the fifty or more pages devoted to this summary of therapeutic procedures. In addition to the subject above referred to, John Rose Bradford has reviewed the Diseases of the Kidneys; Charles W. Bonney, Diseases of the Genito-Urinary Tract, and Joseph C. Bloodgood, the Surgery of the Extremities, Shock, Anæsthesia, Infections, Fractures, Dislocations and Tumors.

**A Practical Medical Dictionary** of Words Used in Medicine with their Derivation and Pronunciation, Including Dental, Veterinary, Chemical, Botanical, Electrical, Life Insurance and Other Special Terms; Anatomical Tables of the Titles in General Use, and those Sanctioned by the Basle Anatomical Convention; Pharmaceutical Preparations, Official in the United States and British Pharmacopœias and Contained in the National Formulary; Chemical and Therapeutic Information as to the Mineral Springs of America and Europe, and Comprehensive list of Synonyms.—By Thomas Lathrop Stedman, A.M., M.D., Editor of the "Twentieth Century Practice of Medicine," etc. Second Revised Edition, Illustrated. New York, William Wood and Company. Price, \$4.50, net, plain; \$5.00 indexed.

The popularity of this dictionary is well indicated by the fact that a large edition has been exhausted in a little more than a year and the author has taken advantage of the second revision to correct the errors of the former and to insert such subjects as the progress of medicine have made necessary. Every effort has been made to include all words that have a legitimate place in Medical Science and the following statement found in the preface is of particular interest to homœopathic practitioners: "The sectarian lines which have divided medical practitioners are, happily, gradually fading away. Homœopathic and eclectic physicians no longer ignore the discoveries of modern experimental medicine but rather are doing their part to advance true science. On the other hand, therapeutists of all schools are learning that there is a virtue in homœopathy and allopathy, that, in fact, there is but one science of medicine, and they are ready to apply any one of these healing principles in suitable cases." On this account, the author states, he has defined the terms peculiar to homœopathic and eclectic therapeutists. We note that his definition of homœopathy is a very impartial and complete one and the author deserves every commendation for his liberal and scientific view of this subject.

In the preparation of this work, special attention has been given to the etymology of the words used in medicine and the source of the words have been indicated as far as possible. The Basle Anatomical Nomenclature have been given the preference in this dictionary and, where they differ from the terms formerly in use they are indicated by a special sign. In the spelling of medical terms, preference has been given to the simple forms and the diphthongs "oe" and "ae" have been dropped.

Dr. Stedman is to be congratulated upon having produced a work that is worthy of the success it has already attained and which will prove a valuable and useful addition to medical literature.

**Children—Their Care and Management.**—By E. M. Brockbank, M.D., (Vict.) F.R.C.P. Honorary Physician, Royal Infirmary, etc. London,

Henry Frowde, Oxford University Press: Hodder & Stoughton, Warwick Square, E. C.

The purpose of this book is to offer to recently graduated doctors and to mothers and nurses some practical advice on the feeding and care of children. It contains no information about medicines, as the author believes that this concerns the doctor only and should be limited to works of a strictly medical nature. Considerable space is devoted to feeding, the hygienic care of the baby and of the nursery and the methods to be employed in training children in proper methods of living. It is a work that can be recommended highly to parents and nurses.

**Diseases of the Stomach, Intestines and Pancreas.**—The new (2nd) Edition, Enlarged. By Robert Coleman Kemp, M.D., Professor of Gastro-intestinal Diseases, New York School of Clinical Medicine. Second Edition, revised and enlarged. Octavo of 1,021 pages, with 388 illustrations. Philadelphia and London: W. B. Saunders Company, 1912. Cloth, \$6.50 net; half morocco, \$8.00 net.

There are few subjects in medicine that are more constantly brought to the attention of the general practitioner than diseases of the stomach. It is likewise true to a large degree that this class of patients are poorly handled by medical practitioners. Very important and rapid advances have been made in the diagnosis and treatment of diseases of the gastro-intestinal canal during the past six or eight years and every general practitioner should include in his library at least one complete and up-to-date work dealing with the recognition and management of these conditions.

In preparing the volume now before us the author has taken pains to furnish such information as will give the general practitioner a working knowledge of the subject and has selected a very great accumulation of material in medical literature bearing upon this class of disease and the methods and procedures that have proven of the most practical value.

The work is divided into four parts. Part I—Deals with the Anatomy and Physiology of the Gastro-Intestinal Tract and General Methods of Examination. Part II—Is devoted to Diseases of the Stomach, including special methods of examination to be employed, various dietetic and hygienic measures that are useful in the treatment of stomach diseases; and then follows a description of the various functional and organic disorders that effect that organ. Part III—Is devoted to diseases of the intestines and in the four hundred pages that are given to this part of the work a very complete and comprehensive description is given to methods of examination and treatment as well as a complete picture of the course of the numerous pathological conditions found in this structure.

About one hundred and twenty pages are devoted to diseases of the pancreas, all of which are thoroughly and carefully described. It has been our fortune to review a number of the most important works that have been published on the subject of the gastro-intestinal disorders and, while all of these have their merits, we do not hesitate to say that Dr. Kemp has produced a work that meets the needs of the general practitioner or internist more fully than any similar work now before the profession. His descriptions of the therapeutic management of disorders of the organs under consideration are particularly

full and practical, and indeed the whole work is characterized by the thoroughness and practicability of the manner in which the subject is presented.

**The Medical Epitome Series**—Microscopy, Bacteriology, and Human Parasitology. A manual for Students and Practitioners. By P. E. Archinard, A.M., M.D., Bacteriologist Louisiana State Board of Health and City Board of Health, New Orleans. Second Edition, Revised and Enlarged. Illustrated with one hundred engravings and six plates. Lea & Febiger, Philadelphia and New York.

In this little volume the author has given the profession a concise presentation of the field of bacteriology and of parasitology in a form that enables the student and practitioner of medicine to secure the information he may desire in the quickest possible time. The subject matter in the present edition has been brought strictly up-to-date and includes chapters on Inflammation and Immunity, the Opsonins, etc.

**The Relief of Enteroptosis.**—The many reflex ills that are caused by enteroptosis emphasize the great importance of overcoming this condition at the earliest possible moment by affording proper abdominal support. Many different belts and devices have been brought forward for this purpose, but none has ever given the satisfaction that the Storm Binder has. This effective supporter has the great advantage of providing adequate support with minimum pressure. As a consequence, although the Storm Binder supplies gratifying relief and brings the abdominal viscera up into position, it does not constrict the abdomen nor offer the slightest obstacle to free muscular movement. For the obese or those afflicted with a relapsed abdomen there is nothing that will prove as thoroughly effective and at the same time afford as complete comfort as a Storm Binder. Made of splendid material, these binders keep their shape and wear indefinitely.

Messrs. Boericke & Tafel have just issued an elegant little booklet on their olive oil. It contains a general review of the history and the medicinal value of olive oil together with a collection of valuable recipes for salads and cooking. Boericke & Tafel claim that you cannot get a better olive oil than theirs in the United States though you can find much that is inferior. If you want a fine quality olive oil keep the Boericke & Tafel brand in mind for you might as well get the best especially as there is very little difference in price.

**The Physician's Duty.**—Physicians are becoming more and more impressed with the value of prophylactic measures. Therefore to instruct patients of the gentler sex in hygienic and sanitary principles and procedures is both a duty and a privilege.

It is a fact, often not entirely appreciated even by physicians, that the vaginal douche, properly employed, should be used frequently even in the absence of any abnormal condition. Despite the opinions sometimes expressed that frequent douching is not advisable, that the natural secretions being sufficiently germicidal should be allowed to remain, etc., it is a matter of common knowledge and experience among women of any degree of refinement that proper toilet of the vaginal tract is as valuable, necessary and indispensable as the use of the tooth brush.

This being true of women whose genital tract is in a normal and healthy condition, it applies with augmented force to the vast portion



of cases, in which there is some abnormal condition present, such as excessive mucous secretions, leucorrhœa, vaginitis, endocervicitis, endometritis, congestion, irritation, etc.

The proper use of the Marvel Whirling Spray Syringe is not only instrumental in the treatment of diseased conditions, but is also of great value as a prophylactic measure.

**A Severe Burn**—By H. B. Lee, M.D., Summerville, S. C.—My first use of antiphlogistine in burns and scalds was accidental. I was called by telephone to Mr. J. T., aged twenty-seven, weight 180 lbs., brickmaker, a steam-pipe having exploded between his legs, scalding him badly. I ordered that no grease of any kind be used, but that cloths soaked in a strong solution of bi-carbonate of soda should be laid on the parts till I could get there. I stopped at a drug store to procure another salve I had used in such cases, and by mistake the clerk gave me two boxes of antiphlogistine. When I reached my patient I found him suffering intensely with a big blister extending from the crotch to the ankle on the inner side of both legs, at least three inches wide and surrounded by a red inflamed surface two inches wide on each side.

I covered the entire injured parts with a thick layer of antiphlogistine (applied cold), put absorbent cotton over all, and after bandaging loosely to keep things in place, took Mr. T. home in my buggy.

The next day I let him leave his room and in three days he was back at work. I did not touch the dressing for five days, and when I took it off the parts had healed entirely.

There are two important points in the use of antiphlogistine. First: put it on thick, thick, thick, using it hot for internal inflammations and cold for burns and scalds. Second: never put cloth over the antiphlogistine, except a thin layer of gauze, if necessary, but put absorbent cotton in thick layers over your first dressing. Don't try to remove it as long as it sticks to the skin for it will let go as soon as it has done its work. I have used this preparation (antiphlogistine) frequently since then in severe burns and scalds and yet have to meet my first disappointment in its curative power.

**The After-Treatment of La Grippe.**—In view of the successive epidemics of La Grippe from year to year, since this disease was first introduced or imported into this country, it is reasonable to presume that the infectious condition referred to is now endemic, and that the present winter will prove no exception to the rule in the incidence of a disorder which is now world-wide in its distribution. If there is any one particular feature of La Grippe which is common to almost all cases, it is the distinct and pronounced prostration that follows the subsidence of the acute symptoms.

While the authoritative opinions may differ as regards the treatment of La Grippe during its febrile or active period, there is no doubt of the essential necessity of supportive and tonic treatment during convalescence. It should be remembered, however, that the physician who prescribes a course of tonic, hematinic treatment, without reference to the digestion or gastro-intestinal sufficiency of his patient, is very liable to "strike a snag." The digestive system of the average "grippe" patient, like his general vital tone, is almost always "below par" and the ordinary iron products are likely to produce gastric irritation and digestive discord generally. Pepto-Mangan (Gude) is particularly serviceable in such an emergency. Its ferruginous content is in readily tolerable

# Fellows' Syrup of Hypophosphites

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## NOTICE—CAUTION

The success of Fellows' Syrup of Hypophosphites has tempted many to offer imitations of it for sale.

As these cheap and inefficient substitutes are frequently dispensed instead of the genuine preparation, Physicians are earnestly requested when prescribing the Syrup, to write "**Syr. Hypophos. FELLOWS**".

As a further precaution, it is advisable that the Syrup should be ordered in the original bottles; the distinguishing marks which the bottles (and the wrappers surrounding them) bear can then be examined, and the genuineness—or otherwise—of the contents thereby proved.

and immediately absorbable condition and is assimilated and appropriated without embarrassment of digestive vigor or strain upon the absorptive or assimilative functions. When prostration is extreme, it is a good plan to order strychnia, in appropriate dosage, in combination with *Pepto-Mangan*. There is no surer, safer or more efficient general hematic medication than this.

**The Work of the International Homœopathic Council.**—The International Council held its first meeting in August last, and is hardly yet provided with a permanent working constitution. It is very desirable in attempting to construct machinery to forward homœopathic interests, that shall have an international and world-wide scope, to "hurry slowly," and we feel sure that nothing will ultimately be lost by deliberation at the beginning. Nevertheless already it has proved possible to do something of value for homœopathy. Our Russian colleagues are threatened with a law that will seriously hamper their powers of dispensing their medicines, and make them dependent on chemists who are largely unsympathetic to homœopathy. The proposals before the Duma are being opposed in the interests of homœopathy, and through the agency of the International Council and the hearty co-operation of European and American colleagues, a store of information as to the general status of homœopathy and the relation of our doctors to chemists and to the business of dispensing has been accumulated and sent to our representative in St. Petersburg, Dr. Leon Brasol. Sweden is suffering from a violent attack of professional bitterness against homœopathy, and a press campaign against our cause and Swedish colleagues has been prosecuted for some time. To effect a counterblast to this, Dr. Petrie Hoyle, assistant secretary to the Council, proceeded to Sweden, at the invitation of the leaders of Swedish homœopathy, and delivered lantern lectures in Stockholm and Göteborg, to demonstrate to eye and to ear the fact that homœopathy is not a petty and declining cause, but one whose claims have been so far made good that it commands all over the world hospitals and institutions, and has won great public support through public conviction of its merits. The lectures were attended by large and influential audiences, and appear to have made a deep impression. Our German colleagues are considering the arrangement of a lecturing tour on similar lines for their own country. Therefore, our readers can realize that even now the Council is neither idle nor ineffective. The great need will be financial. The work the body can do will depend mainly on the support it receives, but enough has already been done to show both that there is work to do, and ability to perform it.—(British Hom. Jour.)

**Personals.**—Dr. Leon T. Ashcraft presented a very interesting and instructive "Report of Some Nephrectomies, illustrated with stereopticon slides" before the last meeting of the Interstate Federation of Homœopathic Medical Societies of New York and Pennsylvania.

Dr. Wm. Hillegas announces the opening of his office at 1807 Chestnut Street, Philadelphia. Hours: 2 to 4 P. M. Eye, ear, nose and throat diseases.

Ella D. Goff, M.D., announces her removal to 204 East North Avenue, N. S. Pittsburgh, Pa. Office Phone, 74 Cedar; Residence Phone, 157-1 Neville.

Dr. Charles Theo. Cutting, '98, of Seattle, Wash., will give a course



of lectures to the senior class of Hahnemann Medical College of the Pacific, San Francisco, Cal., during the spring months on "Insurance Examining."

A most enjoyable dance was held on Saturday evening, December 7th, at Memorial Hall for the benefit of the Homœopathic Hospital of Chester County, which was attended by about forty couples. The hall was decorated with penants and lanterns. On the platform stood an attractive table from which the patronesses, Mrs. Curtis Hannum, Mrs. John Thorp, Mrs. Charles Palmer, Mrs. S. M. Rogers and Mrs. J. Oscar Dicks, assisted by Miss Dorothy Barker, and Charles R. Palmer, Jr., served sandwiches, coffee and fruit punch.

The committee who had the dance in charge were Horace T. Webb, Frank A. Pinkerton, Havard Rogers, Vernon L. Hoffman, Earl Gibson, Roland Stein, and Clarence Worst.

**A Possible Revolution in the Treatment of Infectious Disease.**—Are existing methods of treating bacterial diseases to be fundamentally changed? Do the phylacogens furnish the key to a new and enlightened therapy? Medical and other scientific men are beginning to ask these questions.

What are phylacogens? Briefly, they are sterile aqueous solutions of metabolic substances generated by bacteria grown in artificial media. The name phylacogen (from the Greek) means "phylaxin-producer"—literally, "a guard" and "to produce."

The principle upon which the use of the phylacogens is founded is the theory of multiple infections. Three facts are set forth as the basis of the new therapy:

1. Practically all acute and many chronic diseases are caused by the metabolic products of bacteria.
2. The human subject is the host of micro-organisms that are pathologically latent, but capable of setting up a disease process under certain conditions.
3. The growth of infecting micro-organisms can be arrested and their effects neutralized by products derived from their development in artificial culture media.

Five phylacogens are now available: rheumatism phylacogen, erysipelas phylacogen, gonorrhea phylacogen, pneumonia phylacogen, and mixed infection phylacogen (the last named being applicable to the multiplicity of infections which may be said to be of questionable etiology). They are supplied in rubber stoppered glass bulbs of 10 Cc. capacity and are administered hypodermatically (subcutaneously or intravenously).

Many experienced physicians, representing both private and hospital practice, believe that in the phylacogens we have the most efficient remedial agents yet devised for the treatment of acute and chronic infections.

**New Biological Laboratory.**—A handsome building has recently been added to the group of biological laboratories of H. K. Mulford Company at Glenolden, Pa.

The building is constructed entirely from basement to roof of hollow tile and concrete, making it a fireproof structure throughout.

It is divided into departments, each department being a unit, and complete in itself. The east end of the building is devoted to the handling of serum and globulin products. On the first floor bleedings are

received from the bleeding room, serum or plasma is removed from the clot or from the corpuscles, as the case may be, and the product stored immediately in cold-storage rooms belonging to this group.

When the serum or globulin has been tested and is ready to be finished, it is delivered to the group of antitoxin and serum filling rooms.

Each of the twenty filling and serum rooms is supplied with washed and filtered air. The special apparatus used for this purpose is guaranteed to remove 98 per cent. of suspended matter from the air supplied to these rooms. Not only is the air filtered but its humidity and temperature are controlled, thus giving the employes the benefit of the best possible working conditions.

On each floor glass partitions between the halls and rooms permit the demonstration of the work to visitors without their entering the rooms themselves.

The entire plant is arranged and managed under the unit system. A separate building or group of buildings, or in some cases portions of larger buildings, are devoted to the preparation, standardization, packing and shipping of each product. Each unit is in charge of scientific experts in their particular branch of bacteriology. Cold-storage rooms supplied with cold air from a central refrigeration plant form part of each individual unit arrangement. This makes it possible to keep on hand a large stock of biologicals without danger of deterioration, so that the company is prepared at all times to supply these products and to cope with the enormous demands often created by epidemics of the various infectious diseases.

#### PENNSYLVANIA STATE SOCIETY NOTES.

The Philadelphia Society for Clinical Research, held its annual Christmas meeting at the Pen and Pencil Club, 1026 Walnut Street, being the guests of Doctor Ralph Bernstein, who gave a projectoscopic skin clinic consisting of a lantern demonstration of the "More Common Skin Diseases (in colors)—Their Recognition and Treatment." The meeting was well attended, and a delightful time was had by those present.

Percy A. Tindall, M.D., Secy.

The Clinico Pathologic Society of Philadelphia, held its regular monthly meeting at the Hahnemann College, Saturday evening, December 21, 1912, at 8.30 o'clock. The scientific program consisted of the following papers:

Exhibition of Slides, showing Normal Menstrual Cycle—Dr. N. S. Betts; Exhibition of Photographs and Plates of Cases of Cyclops—Dr. F. O. Nagle; Exhibition of (a) Leukemic Spleen, (b) Perirenal Sarcoma simulating Hypernephroma—Dr. O. F. Barthmaier; Exhibition of (a) Ova of Animal Parasites in Feces, (b) Malarial Slides from Panama—Dr. R. A. Koronski; Butyric Acid Test—Dr. S. W. Sappington.

The nomination of officers took place and the meeting was very interesting, there being a large number of members present.

Benj. K. Fletcher, M.D., Secy.

The Homœopathic Medical Society of the 23d Ward of Philadelphia, held its regular monthly meeting, Wednesday, December 18, 1912, at the office of Doctor C. E. Tegtmeier, 1237 Shackamaxon Street. A very

interesting paper on "Talpis Valgus" was read, after which a hearty discussion took place. The meeting was full of interest, and a large number of members were present.

John D. Boileau, M.D., Secy.

**The Germantown Homœopathic Medical Society**, held its regular monthly meeting at the "Majestic," Broad and Girard Avenue, on Monday the sixteenth of December, 1912, at nine o'clock in the evening. A paper for discussion was presented by Doctor Norman S. Betts on "Some Problems in Gynecological Diagnosis," after which the nomination of officers took place. The meeting proved to be of great interest, and was well attended.

Landreth W. Thompson, M.D., Secy.

**The Hahnemannian Institute**, held its regular monthly meeting on Wednesday evening, December 18, 1912, at 8 P. M. The subject for discussion being "Medical Ethics." Doctor George W. Stewart, the speaker of the evening added much interest to the meeting. The institution dance was discussed by those present.

**The Women's Homœopathic Medical Association of Pittsburgh, Pa.**, held its regular monthly meeting at the office of Doctor Mary E. Coffin, 3823 California Avenue, N. S. Pittsburgh, on Thursday, January 2d, 1913, at 8 P. M. The scientific program consisted of the following: "Homœopathy in the Treatment of Insanity"—Dr. Mary E. Coffin. The meeting was full of interest and a large attendance of members were present. The election of officers for the coming year took place.

Mary E. Coffin, M.D., Secy.

**The Homœopathic Medical Society of the 23d Ward of Philadelphia**, held its regular monthly meeting on Wednesday, January 15, 1913, at the office of Doctor R. E. Tomlin, 2057 No. Eighth Street. A paper on "Practice of Medicine" was read, and proved to be of much interest to the meeting. The meeting was well attended, and a very enjoyable time was had by those present.

John D. Boileau, M.D., Secy.

The Lorgus Company, of West Chester, gave a flower sale on December 10th, 1912, allowing twenty-five per cent. of their sales for the Auxiliary of the new Homœopathic Hospital of Chester County. Mrs. Joseph Leedom, Mrs. Edward S. Darlington, and Mrs. George J. Palmer received the friends of the hospital during the sale.

**The Homœopathic Medical Society of the County of Philadelphia**, held its regular monthly meeting at Hahnemann Medical College, Thursday evening, December 12th, 1912, at 9 P. M. The scientific program consisted of the following:

"A Suggested Physiological Basis for Hahnemann's Psora Theory"—Discussion: Dr. Augustus Korndoerfer, Sr., Dr. Walter M. James, Dr. J. Edgar Belleville; "The Pathology of Glaucoma"—Dr. Frank O. Nagle; "Belladonna in Diseases of the Nose and Throat"—Dr. H. S. Weaver; "A Laboratory Test"—Dr. S. W. Sappington. An amendment to the By-Laws, changing the hour of meeting from 9 o'clock to 8.30 was voted upon. There was a full attendance of members and great interest was shown at the meeting. The following is a brief synopsis of Dr. Korndoerfer's paper:

Hahnemann defined psora as "the oldest, widest spread and most injurious, as well as the most misunderstood chronic miasmatic disease which for thousands of years has afflicted mankind." "A species of inter-



nal itch." He recognized the intimate relation of this miasm to the functions of metabolism.

His use of the term "miasm" included what we to-day do under the term "germ." The "cholera miasm" he describes as dependent upon "an invisible, probably animated and perpetually reproductive contagious matter," which he further describes as composed of myriads of "exceedingly minute, invisible, living creatures, so inimical to human life." He considered all chronic non-venereal forms of disease as dependent upon this psoric miasm.

Sajous, in his epoch-making work, "The Internal Secretions and Principles of Medicine," has given us an entirely new physiologic perspective, one which will enable us to better understand what Hahnemann discovered nearly a hundred years ago.

According to Sajous, the internal secretions bear a distinct relation to the protective powers of the body against disease. The pituitary body with the thyroid, parathyroids and adrenals in their physiologic co-ordination constitute the autoprotective mechanism. The sensory or test organ which is embedded in the partition between the anterior and posterior pituitary bodies, has for its purpose to protect against noxious material that may be present in the blood. Reacting under the influence of any excitant poison in the blood it increases, through the adeno-thyroid center, which it governs, the activity of the adrenals and of the thyroid and parathyroids. Thus we have an increase of adrenalin, with corresponding increase of trypsin, which latter acts as a proteolytic ferment capable of reducing bacterial toxins, toxalbumins, vegetable poisons and venoms. The adreno-thyroid center also stimulates the functional activity of the thyroid and parathyroids, increasing their specific secretions and through them increasing the sensitiveness of all cells, including bacteria, thus increasing their vulnerability to phagocytes. The autoprotective power of the body depends upon the normal development of these functional activities.

When properly interpreted the process harmonizes not only the known facts of physiologic autoprotection, but it clears the obscure explanations of psora and throws a new light upon the philosophy of the principle of similars and the utility of the minimum dose.

In the final analysis we find that the adreno-oxidase represents Ehrlich's ambroceptor; the trypsin, Ehrlich's complement; the spleen and leucocytes furnish the nucleoproteid, while the thyroidase represents Wright's opsonins.

A critical comparison of the symptoms dependent upon hypothyroidia with those given by Hahnemann as indicative of psora will show such a marked similarity that we must attribute them to one and the same cause—i.e., an impairment of the autoprotective mechanism. We, therefore, may conclude that the depraved constitutional condition known as psora is but a chronic state of faulty functioning of one or more of the elements essential to the autoprotective forces.

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#### CHAUFFEUR'S COMPLETE OUTFIT SACRIFICED.

Consisting of elegant mink fur lined coat, Persian lamb collar \$35, pair of elegant bear robes \$15 each, raccoon cap \$5, pair of fur gloves \$4, pair of goggles 50c., one pair leather leggings \$3.50. Will sell separately or the lot, all new, never worn. Original price \$225. G. CHASE, 118 East 28th St., New York.

# THE HAHNEMANNIAN MONTHLY NEWS AND ADVERTISER

A Medical Newspaper

FEBRUARY, 1913

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**Clinical Methods**—A Guide to the Practical study of Medicine.—By Robert Hutchison, M.D., F.R.C.P. Physician to the London Hospital, etc., and Harry Rainey, M.D., F.R.C.P., Ed., F.R.S.E., Assistant Physician to the Royal Infirmary, Edinburgh. Contains eleven colored plates and one hundred and forty-eight figures in the text. Fourth edition, thoroughly revised. New York, Funk and Wagnalls Company. Price, \$2.50 net.

This little volume is a veritable mine of information as regards the subjects of clinical investigation and clinical diagnosis. Despite its unpretentious form and its very low price, we know of no similar work in all medical literature that more thoroughly or practically covers the subject to which it is devoted, than this volume. It is not intended as a treatise upon medical diagnosis but to serve as a guide to the investigation of cases including the physical examination and the examination of the various secretions and excretions of the body as well as clinical bacteriology.

It is divided into fourteen chapters, the more important of which deal with "Case-Taking," "General Physical Examination," "Examination of the Blood," "The Urine," "The Nervous System," "Eye," "Ear,"

"Nose," and "Throat," "Examination of Children," "Examination of Pathological Fluids," "Clinical Bacteriology." The work is freely illustrated and the information contained in it is conveyed in the fewest possible words.

The fourth edition has been thoroughly revised and brought fully up to date. It is a work that should find a useful place in the working library of progressive medical men.

**Oxford Medical Publications—Surgery of the Rectum for Practitioners.—**

By Sir Frederick Wallis, M.B., B.C., Cantab., F.R.C.S. Surgeon to Charing Cross Hospital, etc., etc. Henry Frowde: Oxford University Press, 35 W. 32nd St., New York.

After discussing the various controlling inflammatory diseases of the rectum, sigmoid and colon, the author takes up Pruritus Ani, Rectal and Peri Rectal Abscesses, Fistula, Hæmorrhoids, Carcinoma of the Rectum and Rectal Diseases in Childhood. The work is freely illustrated and can be recommended as an accurate and practical guide to the physician or surgeon desiring information in regard to the diagnosis and treatment of rectal diseases.

**Text-Book of General and Special Pathology for Students and Practitioners.—**

By Henry T. Brooks, M.D., formerly Professor of Pathology at the New York Post-Graduate Medical School and Hospital, etc., etc. Illustrated with five hundred and twenty-five half-tone and other text engravings (110 in colors), also fifteen full-page plates in colors, containing no figures. Philadelphia: F. A. Davis, Company, Publishers. Price, \$6.00 net.

It was originally intended by the writer to issue a translation of the third edition of "Grundriss der Pathologischen Anatomie," published 1904, by Professor Robert Langerhans of Berlin. The important and rapid advancements that have been made in pathology since that time however, have made it necessary to change and augment the subject matter to such an extent that the book is now presented as an independent volume. Many of the best portions of the German text and the most excellent illustrations have been used. The work is intended to serve as a guide to the undergraduate student and the study of both gross and microscopic pathologic anatomy and at the same time to give such information as will enable both student and practitioner to interpret clinical symptoms and the basis of pathological conditions. An excellent chapter on immunity has been contributed by Professor Allan J. Smith of the University of Pennsylvania. The work contains 525 illustrations, 110 of which are colors.

**Medical Men and the Law.—A Modern Treatise on the Legal Rights,**

Duties and Liabilities of Physicians and Surgeons. By Hugh Emmett Culbertson, Esq., member of the Ohio and New York Bars; Contributing Editor to many Legal Publications. Octavo, 325 pages. Cloth, \$3.00. net. Lea & Febiger, Publishers, Philadelphia and New York, 1913.

This unique work touches the personal interests of every physician and surgeon, and also of every practitioner in any branch of the art of healing. It deals with the duties, rights and liabilities of the professional man toward the public as settled by law, and also the legal relations of the regular profession to practitioners of the many schools of healing now in vogue, as well as the status of such healers in the eye



of the law. It behooves every medical man to know the multitude of points in which his relations to the public and his fellow-practitioners are subject to a well settled body of law, to the end that he may avoid unexpected trouble on the one hand, and know his rights and powers on the other. This new work is comprehensive and authoritative, and its possession and perusal will save many times its cost if only in the item of collecting bills, as well as many an anxious hour. The well-established physician who has bought this knowledge in the costly school of experience will appreciate the value of such a work and will give it a place in his library within easy reach for frequent consultation. The young physician will be wise to profit by the knowledge so conveniently placed at hand, and will be glad to avoid the trials and troubles of his elders. Conversely it affords the lawyer a knowledge of the relations of his profession to that of medicine. It is an unusually serviceable book

**Specific Diagnosis and Medication.**—By the late John M. Scudder, M.D. 12th edition reprinted. 12mo., 819 pp., cloth \$3.00. John K. Scudder, Publisher, 630 W. 6th Street, Cincinnati, Ohio

The present volume is one that has been before the profession for many years and the present edition has been issued in response to repeated requests from physicians who wish the original book just as it was issued before the author's death. The complete volume is divided into two parts. The first part consists of about four hundred pages being devoted to the subject of diagnosis; the second part consists of about four hundred pages and is devoted to treatment. This work is of especial interest because the practice of modern eclectic physicians is based chiefly upon the writings of this author. To the homœopathic practitioner it is certainly a work of extreme interest and we are interested to note that the methods of prescribing that Professor Scudder found by experience to be most valuable were, on the whole, quite similar to those recommended by Hahnemann. The two parts of the book can be purchased separately. The price of that portion relating to "Medication" \$2.00, and of the part relating to "Diagnosis" \$1.50.

**Building A Profitable Practice.**—Being a Text-Book on Medical Economics.—By Thomas F. Reilly, M.S., M.D., Professor of Applied Therapeutics, Medical Department Fordham University, N. Y.. Philadelphia and London, J. B. Lippincott Company.

The author of this work has endeavored to present to the medical profession and especially to the beginner in medical practice some ideas relating to the economic and business side of the profession that will help him to solve some of the numerous problems that present themselves in practice. Among the subjects discussed we note chapters on "Post-Graduate Study," "The Fitting up of an Office," "Medical Fees," "Collections," "Legal Medicine," "Professional Ethics," "Personal Manners," etc. The work is one which will fill a long felt need and might be profitably read by every physician young and old.

**Psychoanalysis: Its Theories and Practical Application.**—By A. A. Brill, Ph.B., M.D., Chief of the Neurological Department of the Bronx Hospital and Dispensary; Clinical Assistant in Psychiatry and Neurology at Columbia University Medical School. Octavo of 337 pages. Philadelphia and London: W. B. Saunders Company, 1912. Cloth, \$3.00 net.

During recent years a great deal has been written, especially by

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PHILADELPHIA, PA.

Freud in regard to Psychanalysis in the diagnosis and treatment of nervous disorders. The object of this volume is to present the practical application of Freud's theories and to give the profession an adequate idea of just what these theories are. In conjunction with a large number of physicians the reviewer has always been inclined to the belief that Freud has unduly magnified the importance of certain factors in the production of neurotic conditions and that his methods in America at least, are not capable of any wide-spread application. The subject, however, is undoubtedly one of importance, and physicians who are interested in the subject will find a very clear and complete exposition of the principle and methods of psychanalysis set forth in this volume.

**Oxford Medical Publications: Consumption in General Practice.**—By H. Hyslop Thompson, M.D., D.P.H., Medical Superintendent Liverpool Sanatorium. Publishers: Henry Frowde and Hodder and Stoughton, New York address, 35 West 32nd Street.

During the last decade a great many works have appeared on the subject of tuberculosis. The fault that we find with the majority of them is, that they are too voluminous and devote a great deal of space to conveying information that could be just as readily set forth within a comparatively small space. The present work has the merit of being concise as well as complete. The book contains 325 pages of medium size and printed in large type. The author first takes up the diagnosis which is gone into quite carefully. Section II deals with Prognosis and Section III with Treatment. Chapters on the use of tuberculin are included. It is a reliable and up-to-date work on a very important subject.

**London Medical Publications: Diseases of Women.**—By Thomas George Stevens, M.D., B.S., (Lond.); F.R.C.S., (Eng.); M.R.C.P. (Lond.) Obstetric Surgeon with Charge of out patients, St. Mary's Hospital, etc., etc. With 202 illustrations. London: University of London Press, by Hodder and Stoughton and Henry Frowde and 35 West 32nd St., New York.

This work is the outcome of ten years' experience in teaching gynecology to medical students. The author believes that the subject must be presented on a pathological basis in order that many supposedly mysterious conditions may be clearly explained and recognized. The diseases have been classified partially on a pathological and partially on a clinical basis. Though the work is a comparatively small one containing about 400 pages, it is profusely illustrated, containing 202 illustrations many of which occupy a full page. The micro-photographs are especially worthy of careful study.

**Oxford Medical Publications: Minor Surgery.**—By Leonard A. Bidwell, F.R.C.S., Senior Surgeon to the West London Hospital, etc., etc. Second edition revised and enlarged, with one hundred and twenty-nine illustrations. London: University of London Press, New York Agency, 35 West 32nd Street.

In this work the author aims to give simple and clearer directions for the management of every day surgical cases that the physician is brought in contact with in the office or at the bed-side. As a rule a single method of treatment has been described, the author preferring to give only that which has proven of practical value rather than confuse



the reader by describing several methods of limited application. The technique of minor surgery, the method of procedure in various minor operations, diagnostic punctures and aspirations, the use of plaster of Paris, splints, bandaging, method of obtaining blood for various diagnostic tests, treatment of asphyxiation, etc., are all described. It is a very practical little volume and will fill a useful place in the library of every practical physician.

**Oxford Medical Publications: A Manual of Elementary Zoology.**—By L. A. Borradaile, M.A., Lecturer in Zoology in the University of Cambridge, etc., etc. London: Henry Frowde and Hodder and Stoughton. New York, 35 West 32nd Street.

The study of the biological sciences is becoming more and more recognized as an important preliminary step for the prospective student of medicine. Practical and reliable works on these subjects should therefore demand the careful attention of the profession. The present volume has been devised especially for the student and the author has treated of the animals which are most often studied in courses on elementary zoology and a preliminary chapter on the animal organism. The writer next describes the frog, insects, pigeon, rabbit, mammalia, etc. Under each subject described we find the complete description of the anatomy of the various organs and structures together with plates illustrating these points and also certain facts relating to their natural history, methods of reproduction, etc. It is a work which can be highly recommended to those desiring practical information along these lines.

**The Animal Kingdom** Considered Anatomically, Physically and Philosophically. By Emanuel Swedenborg. Part on the Organs of Generation, and the Formation of the Fœtus in the Womb, after which follow Chapters on the Breasts and the Periosteum. Translated from the Latin by Alfred Acton. 398 pages, 8vo. With 10 anatomical plates. Cloth, \$3.00 net. Postage, 20 cents. Philadelphia, Boericke & Tafel, 1912.

The reviewer feels compelled to express his inability to review this work in any complete or satisfactory manner. It appears to be a translation of Parts 4 and 5 of Swedenborg's work on the Animal Kingdom and sets forth Swedenborg's views on the subject of "Generation." To those who are interested in this subject, it will no doubt prove of great interest.

**Pocket Manual of Homœopathic Materia Medica**, Comprising the Characteristic and Guiding Symptoms of all Remedies.—By Wm. Boericke, M.D., Professor of Materia Medica and Therapeutics at the Hahnemann Hospital College, San Francisco, Cal., etc. Fifth Edition, revised and enlarged with the addition of a repertory by Oscar E. Boericke, A.B., M.D., late lecturer on Materia Medica at Hahnemann Medical College, Philadelphia, etc. Published by Boericke & Runyon, N. Y., 1912.

The popularity and usefulness of this well known work among American Practitioners of homœopathy is shown by the fact that it has now reached its fifth edition. The reason for this popularity, in our opinion, is the fact that the authors have succeeded in presenting

to the profession a veritable mine of information in regard to drugs and their indications in diseases, in a form that is readily available for reference in the office or at the bed side. The present edition conforms in its general make-up to the previous ones and is an up-to-date epitome of the whole homœopathic materia medica. We note that the repertory section has been completely remodeled and much new material has been incorporated in it. It is a work that reflects great credit upon its authors and is a valuable addition to the library of every homœopathic prescriber.

**Oxford Medical Publications: Diseases of the Eye.**—By C. Devereux Marshall, F.R.C.S., Surgeon to the Royal London (Moorfields) Ophthalmic Hospital, etc., etc. Fully illustrated. London: University of London Press, and 35 West 32nd Street, N. Y.

This work is designed for the use of students and those practitioners who, while they do a certain amount of eye work, cannot be considered as experts. With this object in view the work has been made as practical as possible. The untried methods of diagnosis and treatment have not been entered into. The work is contained in a volume of about three hundred pages and is well adapted to the purposes for which it was designed.

**Genitourinary Diseases and Syphilis.**—By Henry H. Morton, M.D., Clinical Professor of Genito Urinary Diseases in the Long Island College Hospital, etc., etc. Illustrated with 275 half-tones and photo-engravings and 18 full-page insert plates, 11 of which are in colors. Third edition revised and enlarged. Philadelphia, F. A. Davis Company.

Since the publication of the last edition of this popular work, many advances in the development of Genitourinary diseases have been made and our knowledge of syphilis has made greater progress than the preceding two or three hundred years. The author has taken advantage of this new edition to reconstruct entirely the chapters dealing with the diagnosis and treatment of syphilis and has discussed these matters very completely as well as devoting a special chapter to the Wassermann reaction.

The scope of the work covers the disease of the urethra, of the bladder and of the kidneys as well as of syphilis and sterility. Numerous illustrations have been introduced which serve to illustrate any doubtful points in the text.

**New Laboratory at Hahnemann Medical College, Philadelphia.**—A beautiful laboratory for use of students in Chemistry and Pharmacy has recently been completed at the Hahnemann Medical College.

Several ideas that may be of interest have been carried out in the construction of this laboratory. The desks of the four long desks are covered with white tiling which has been laid in a thick bed of acid proof cement. The waste drains are in the middle of each table and slope in but one direction which plan reduces the amount of plumbing to a minimum. A flush pipe at the highest point in each drain may be used to insure the waste chemicals from rapidly destroying the plumbing. The bottle shelves are low but of ample size and are placed low so as not to obstruct the light and allow a complete view about the laboratory. The laboratory is well lighted by large windows, three on

the north and three on the east. Each student has an individual locker well equipped with apparatus and sufficiently large to keep his stool,urette stands, ring stands, large bottles, etc. The laboratory is equipped with a modern fume chamber and water still, also a black board fifteen feet long. A cordial invitation is extended to all to inspect this laboratory at any time.

**Cactus Grandiflorus**.—Thirty thousand physicians, graduates of all schools, were recently asked their opinions as to the vegetable remedies of greatest value in their practice. Of the 10,000 responses Cactus Grandiflorus received 6,239 votes (*Journ. Am. Pharm. Assoc.*). It was mentioned oftener than any other drug, official or non-official. This reminds us of Cactina Pillets, which were introduced to the pharmaceutical and medical professions in 1889 by Mr. Sultan, of the Sultan Drug Company. This is the original definite product of cactus, presenting the drug in a constant and reliable form; and the thousands of physicians who have used it in their practice for the past twenty-four years have attested to its undoubted value as a cardiac remedy of great usefulness in the treatment of functional heart troubles. As the makers of Cactina Pillets have consistently advertised this product in the legitimate medical press, it would seem that their great faith in the drug is now justified in an ample manner.

**Diabetes—Mellitus.**—I am undertaking an exhaustive research into the pathology, etiology and dieto-therapy of Diabetes Mellitus. I am very anxious to hear from every physician in the United States who has a case under treatment, or who has had any experience in the treatment of this malady. Von Noorden says: "the best treatment for the diabetic is the food containing the greatest amount of starch which the patient can bear without harm." If any physician who reads this has similar or contrary experience, and would take the trouble to write me, I would esteem it a special privilege to hear from him, if only a postal card. Kindly address: William E. Fitch, M.D., 355 W. 145th Street, New York City.

**Personals.**—Dr. Julian Gould Waylan announces her removal, March 1st, 1913, to Galen Hall, Wernersville, Penna., as resident physician.

Dr. J. W. Frank announces the removal of his office from 114 N. 17th Street to 2037 Chestnut Street, Philadelphia. Office Hours: 8 to 10 A. M. except Saturdays 8 to 9; 5 to 6 P. M.; 7 to 8 P. M. Sunday and Wednesday afternoons and evenings by appointment only.

Dr. A. G. Koehler has opened an office at 113 Main Street, Oshkosh, Wis.

Dr. John A. Fischer announces the opening of offices at 254 South Sixteenth Street, Philadelphia. Hours: 9 to 12 A. M., except Sunday. Residence: 505 Green Street. Hours: 5.30 to 7.30 P. M.; Sundays: 8 to 11 A. M.

**Practice For Sale.**—Unapproved homœopathic practice offered in one of finest moderate sized cities in State of Nebraska; eastern part; county seat, wealthy community. Practice free on purchase of office property located in business section on paved street, all modern con-



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Freedom from Acid reaction,

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Pre-eminence in arresting disease.

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ventures, reception room, consultation and drug rooms, auto shed and hall. Price \$2100. Cash payment of \$1500 required. The only Homeopathist in county, has been located here for 22 years, right man can do good business from start, and opportunity for development. Come and look things over, or write for further information. Dr. H. S. Hewitt, Seward, Nebraska.

The Southern Homœopathic Medical Association, at their meeting held in Richmond, Va., October 15th, 16th and 17th, elected the following officers for the ensuing year:

Dr. Wellford B. Lorraine, Richmond, Va., president; Dr. H. E. Koons, Danville, Va., 1st vice-president; Dr. J. Burnie Griffin, St. Augustine, Fla., 2nd vice-president; Dr. Myron A. Newmann, Norfolk, Va., treasurer; Dr. Lee Norman, Louisville, Ky., secretary.

Application blanks and all other information regarding the Association may be obtained from the secretary, Lee Norman, 712 W. Broadway, Louisville, Ky.

**Obituary.**—Dr. John H. Yeagley, sixty years old, one of York's prominent physicians, died Tuesday afternoon, December 17th, 1912. He was stricken one week previous with pneumonia. Dr. Yeagley was educated at University College, Coburg, Canada, and Hahnemann Medical College, Philadelphia. He leaves a widow and three children.

Dr. Richard Allen died at his home, 1405 Oxford Street, Frankford, Pa., after an operation for organic trouble. He was eighty-four years old. Doctor Allen was a graduate of Hahnemann College, and began the practice of his profession in Frankford when he was twenty-one years old. He is survived by a widow and three daughters.

Dr. Hugo Richard Arndt, Field Secretary, American Institute of Homœopathy, died at Cleveland, Ohio, January 2nd. Dr. Arndt's death was due to pneumonia to which he succumbed after a few days' illness. For many years Dr. Arndt has filled a very prominent place in the homœopathic profession, having served in the capacity of teacher, author, editor and field secretary of the institute. There are probably few men in the homœopathic profession more widely known or more affectionately esteemed.

Dr. William E. Green, ex-President of the American Institute of Homœopathy, died at his home in Little Rock, Arkansas, January 6th, 1913.

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#### PENNSYLVANIA STATE NOTES.

The Homœopathic Medical Society of the County of Philadelphia, held its regular monthly meeting at Hahnemann Medical College, Thursday evening, January 9, 1913, at 8.30 P. M. The scientific program consisted of the following: "A Possible Factor in the Causation of Cancer," Horace Packard, M.D., Boston; "Gastric Surgery," Robert V. White, M.D., Scranton Pa. There was a full attendance of members and great interest was shown at the meeting.

Wm. M. Sylvis, M.D., Secy.

**The Clinico Pathologic Society of Philadelphia** held its regular monthly meeting at Hahnemann College, Saturday evening, January 18, 1913, at 8.30 P. M. The papers read were as follows: "Bowel Obstruction due to Meckel's Diverticulum," C. Albert Bigeler, Jr., M.D.; "A Case of Recurrent Pneumonia," W. R. Williams, M.D.; "Fractures of Larynx," F. W. Smith, M.D. These papers were well presented, and proved to be a very interesting feature of the meeting. A discussion of clinical cases was entered into, and was thoroughly enjoyed by those present, after which the election of officers took place.

Benj. K. Fletcher, M.D., Secy.

**The Germantown Homœopathic Medical Society** held its regular monthly meeting at the "Majestic" Broad and Girard Avenue, on Monday evening, January 20, 1913, at 9 P. M. A hearty discussion on many interesting topics was entered into by those present, after which the election of officers took place, those who were nominated being: President, Dr. F. L. Abbott; vice-presidents, Dr. E. M. Howard, Dr. D. Roman, and Dr. H. S. Weaver; recording secretary, Dr. W. C. Baker; corresponding secretary, Dr. L. W. Thompson; treasurer, Dr. I. B. Gilbert; Judiciary Committee, Drs. W. H. Keim, W. Speakman, T. J. Gramm, J. A. Fisher, C. M. Brooks, W. L. Hicks, and N. S. Betts; Censors, Drs. N. F. Lane, E. F. Humphreys, L. W. Reading, W. C. Powell and G. P. Stubbs. The meeting was full of interest, and was well attended.

Landreth W. Thompson, M.D., Secy.

**The Philadelphia Society for Clinical Research** held its regular monthly meeting at the "Majestic," Broad Street and Girard Avenue, on Monday evening, January 27, 1913, at 9 P. M. A report of a clinical case from each member made the meeting a most interesting one. The meeting was thoroughly enjoyed by a large number of members who were present.

Percy A. Tindall, M.D., Secy.

**The Hahnemann Institute** held its regular monthly meeting on Wednesday evening, January 15, 1913, at 8 P. M. Great interest was shown at the meeting, the subject for discussion being "Medical Ethics." There were a large number of members present, and the meeting proved to be a very enjoyable one.

George W. Stewart, M.D., Secy.

**The Women's Homœopathic Medical Association of Pittsburgh, Pa.,** held its regular monthly meeting at the office of Dr. Ella D. Goff, 204 E. North Avenue, N. S., Pittsburgh, on Thursday evening, February 6, 1913, at 8 P. M. The scientific program consisted of the following: "Clinical Scarlet Fever," Ella D. Goff, M.D.; "Acute Affection of the Ear," Lydia B. Pierce, M.D. The meeting was a very interesting one, and a very enjoyable time was had by those present.

Mary E. Coffin, M.D., Secy.

**The Homœopathic Medical Society of Chester, Delaware and Montgomery Counties,** held its mid-winter meeting at the Colonnade Hotel, Philadelphia, Tuesday, February 11th, 1913, at 1 P. M. Luncheon being served at 1.30 P. M. The addresses consisted of the following: "Progressive Co-ordination of the Mind and Body," from a physical standpoint, demonstrated by a series of muscular movements—Carlton



B. Sanford, Physical Director, Y. M. C. A., Chester Pa.; "Heart Aneurism," illustrated cases by Prof. Wm. Rendell, M.D., Philadelphia, Pa. Professor Herbert L. Northrop, M.D., of Philadelphia, opened the discussion of "Aneurism" with presentation of case. The meeting was an interesting one, and was attended by a large number of members.

Isaac Crowther, M.D., Secy.

The Homœopathic Medical Society, of New Castle County, held its bi-annual banquet, at the Hotel Du Pont, Wilmington, Del., Friday evening, January 31st, 1913. Those responding to toasts were: Dr. Wm. E. Van Lennep, Dean, Hahnemann Medical College, Phila., Pa.; Dr. S. W. Sappington, Phila., Pa.; Dr. D. P. Maddux, Chester, Pa.; Hon. Robt. H. Richards, Wilmington, Del., and Dr. Wm. W. Speakman, Phila., Pa. There were a large number present at the banquet, and a delightful time was had by those present.

Julian Adair, M.D., Secy.

The Homœopathic Medical Society of Chester County held its bi-monthly meeting at the Green Tree Inn, West Chester, Pa., on Thursday afternoon, February 6, 1913. The session began as usual with a dinner at the hotel, after which an informal business meeting was held, Dr. Howard Terry, of Phoenixville, presiding. The meeting was largely devoted to formulating plans for the new hospital, and encouraging reports were heard relative to subscriptions received for the project.

Committees were appointed to secure plans for remodeling the "Warrington Mansion," recently purchased by the hospital board, and for purchasing furniture and medical supplies for the hospital. They will take possession of the property on April 1st, and will at once proceed to remodel the dwelling.

Physicians from Malvern, Downingtown, Kennett Square, Phoenixville and West Chester were present at the meeting.

South Philadelphia Medical Association held its regular monthly meeting January 21, 1913, at the residence of Dr. Benj. K. Fletcher. Dr. Fletcher gave a practical demonstration of the up-to-date methods of blood examination.

John J. McKenna, M.D., Secy.

**The Transportation Committee: Official Route—Chicago to Denver.**—The chairman of the Transportation Committee takes pleasure in announcing to the members of the American Institute of Homœopathy that it has selected as the official route from Chicago to Denver for the session of 1913, the Chicago and Northwestern and Union Pacific lines.

Facts, conditions and premises inviting this selection are as follows: Double track system from Chicago to Julesburg.

Road-bed splendidly ballasted with Sherman Hill gravel.

Automatic block signal system, insuring perfect safety.

Splendid dining car service with ample facilities.

The pledge of as fine a train or trains as ever left Chicago.

Equipment of the very best and latest models of sleepers.

Two or more diners for each train.

Latest style observation cars for each train.

Personal attendance Chicago to Denver.

Other points that determined the selection by the chairman, upon whom, by the courtesy of his fellows of the committee, the responsibility rests, are as follows:

A different route to Denver in 1894.

A different route to Pasadena in 1910.

Cavil at each of those selections by disappointed journals.

Determination to avoid cavil this year if possible.

Possible stop at Sterling for auto ride through valley and out upon the uplands.

Favorable leaving time and favorable Denver arriving hour.

Desire to be fair and courteous to all lines of railroad.

It is not believed amplification is greatly required. The Chicago and Northwestern line is one of the highest class, not excelled for road-bed, speed and equipment in the country. Its service is unsurpassed and unsurpassable. Its magnificent new twenty million dollar station affords us a splendid waiting place and a comfortable station from which to make the start. This line is double-tracked all the way from Chicago to Omaha.

The Union Pacific is the pioneer line across the continent. It also is double-tracked from Omaha to the Colorado line. It is supplied with automatic block signal system from Omaha to Denver, as is the Northwestern from Chicago to Omaha. No more perfect lines exist in this or any other country.

Dr. Harlan Wells has been asked to take care of the profession from Philadelphia and vicinity to Chicago. Dr. DeWitt G. Wilcox has been asked to operate a New England Gazette Special from Boston to Chicago. Dr. J. B. Garrison has been asked to look after the special interests of the New Yorkers. All are invited to join the Institute Special at Chicago. It is hoped there may be complete satisfaction with the arrangements, and uniformity of action for the Institute's good and the pleasure of its members who attend.

C. E. Fisher, Chairman.

**American Institute of Homœopathy.**—The American Institute of Homœopathy will hold its next annual meeting in the New Albany Hotel, Denver, Colo., July 6-12, 1913. The Chicago & Northwestern-Union Pacific Route has been chosen as the official route. Address communications concerning transportation to Dr. C. E. Fisher, Sterling, Colo.

Dr. W. A. Dewey, having declined to serve as chairman of the Press Committee, Dr. Burton Haseltine was appointed in his stead.

Dr. Grant S. Peck, 226 Majestic Bldg., Denver, has been appointed by President Hinsdale, chairman of the Committee on Local Arrangements.

The subject of Social Hygiene has been added as a part of the work of the Bureau of Sanitary Science and Public Health.

Genito-Urinary Diseases are a part of the work of the Bureau of Dermatology, whose correct title is "Bureau of Dermatology and Genito-Urinary Diseases."

The Committee of Hotels and Accommodations for the Denver, 1913, meeting wish to report that we have made arrangements with the New Albany Hotel for all necessary room for exhibits, meetings and conventions. Farther, we have arranged with the same Hostelry, whereby they agree to furnish at least 70 rooms at a rate of \$2.00 per day, 90 rooms at \$2.50 per day, 100 rooms at \$3.00 per day, 10 rooms at \$4.00

per day. We have also arranged through the Albany with the Kaiserhof and The Standish for a number of rooms at \$1.00 without bath to \$2.50 per day with bath. With any of the above there will be reductions made where more than one occupies the same room. Meals may also be had at the Albany at regular standard prices. We have the above prices in a guaranteed signed contract, so no one need be overcharged in the slightest. In addition to the above there are 9 or 10 first class hotels within a radius of five blocks.

Our Mr. Paget is the manager of the Albany, and it is our wish that all communications regarding reservations be sent directly to him, this to apply whether you wish rooms at the Albany, the Kaiserhof, or the Standish, or elsewhere.

Alerting you of your comfort next summer and urging that you communicate early with Mr. Paget whose address is the New Albany, we are

Yours most cordially,

Judge Jas. H. Teller,

Mr. F. W. Paget,

Dr. L. B. Wheeler,

Dr. E. B. Swerdfeger, Chairman.

**To-Morrow's Medical News.**—Several thousand people able to pay moderate fees will be treated free in the dispensaries of the city.

Every ten seconds a baby under one year of age will die somewhere in the civilized world.

Several hundred prescriptions for semi-secret nostrums will be written by indolent and incapable physicians.

Several debilitated young women who work ten hours a day in factories, at ten cents an hour, will apply to their physicians to be "built up."

An absolutely normal appendix will be found upon opening the abdomen of a patient suffering from "acute appendicitis."

An incipient cancer of the cervix and several cases of "closed" tuberculosis will pass unrecognized through the hands of physicians.

Ten per cent of sugar will be found in the urine of a surgical patient who has failed to heal.

The Wassermann reaction will be found still positive in a patient in the early stages of syphilis after most intensive courses of salvarsan and mercury.

A physician will receive a check from a surgeon for having acted as "first assistant" at an operation on a referred patient who has paid the operator what he supposes to be the operator's bill and the physician what he supposes to be the physician's bill, but who has no knowledge of the aforesaid transaction.

Several score physicians will be consulted by young matrons by reason of delayed menses and fear on the part of the latter's friends and relatives that they are "not strong enough" to bear children.

In a young woman lithographer, who has inhaled bronze dust regularly for ten years in the course of her work and who is the sole support of her mother and young sister, will be found the signs of incipient tuberculosis.

A hundred or more young men will have their prostates massaged and their urethras irrigated for the fortieth time, with no apparent diminution in fluids or bacteria.

The consummation of many "combined vaccine" successes will be noted

A. C. J.



# THE HAHNEMANNIAN MONTHLY NEWS AND ADVERTISER

A Medical Newspaper

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MARCH, 1913

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**An Index of Treatment by Various Writers.**—Edited by Robert Hutchison, M.D., F.R.C.S., Surgeon to St. Mary's Hospital, etc. Revised to conform with American usage by Warren Coleman, M.D., Professor of Clinical Medicine and Applied Pharmacology, Cornell University Medical College, etc., etc. Sixth edition revised and enlarged. New York, William Wood & Company.

This work is intended for the private practitioner with a complete guide of treatment in moderate compass and in a form convenient for reference. The work, as its name indicates, is devoted entirely to treatment and in its 1050 pages contains a summary of all known methods of treatment medical and surgical. Each article has been written by an authority on the subject under consideration and the publishers have been fortunate in securing the co-operation of some of the most eminent physicians in the English speaking world. While the writers have endeavored to present every known therapeutic measure of value, care has been taken to avoid embarrassing the reader with a large choice of procedures and, therefore, those have been described which the writers have considered simplest and most effective.

The book is essentially an English work and the American editor has largely confined his efforts to adapting the English prescriptions to the United States pharmacopœia. Other modifications of similar note have been made for the purpose of adapting the work to the American reader. In the sixth edition the writers have been enabled to correct the errors and omissions of the previous ones and, as the work now stands, it is undoubtedly the most complete and comprehensive summary of modern therapeutic measures printed in the English language. It is a work that should be in the library of every practical physician.

**Safe-Guarding the Special Senses: General Advice Regarding the Use and Preservation of the Eyes, Nose and Throat.**—By Henry O. Reik, M.D., formerly Associate in Ophthalmology to Otology at the Johns Hopkins University, etc. Philadelphia: F. A. Davis Company, Publishers, 1912. Price 75 cents.

The object of this little volume is to furnish all the leading information regarding the normal use and functions of the organs of special sense and how a healthy condition of these organs may be maintained. It can be recommended as a very practical and sensible book to those desiring information of this character.

**London Medical Publications: Treatment after Operation.**—By Wm. Turner, M.S., F.R.C.S., Senior Surgeon to the 'Dreadnought' Seamen's Hospital, Greenwich, etc., and E. Rock Carling, B.S., F.R.C.S., Surgeon to the 'Dreadnought' Seamen's Hospital, Greenwich, etc. With a chapter on the Eye by L. V. Cargill, F.R.C.S., Senior Ophthalmic Surgeon and Lecturer in Ophthalmology, King's College Hospital, etc. London: University of London Press. Published for the University of London Press, Ltd., by Hodder & Stoughton and Henry Frowde. Price \$3.75. New York Agency: 35 West 32nd Street, N. Y.

The writers of this volume have endeavored to set forth in a practical manner the methods that they habitually employ in the after-treatment of operation cases. The value of the book to the general practitioner and medical student lies in the fact that they have avoided measures that are of doubtful value and have simply given those that experience has shown to be of the greatest practical value. A large variety of subjects are covered in the book among which may be mentioned Anaesthesia, Wounds, Shock, as well as detailed descriptions of special methods to be employed after operations on the various organs of the body.

A special chapter on the eye has been added by L. V. Cargill, which contains many practical points on the care of patients recovering from operations on the eye. The work is freely illustrated and the general typography is excellent.

**Making Good on Private Duty: Practical Hints to Graduate Nurses.**—By Harriet Camp Lounsbery, R.N., President West Virginia State Nurses Association, etc. Philadelphia and London: J. B. Lippincott Company.

This little volume is designed for the purpose of helping the young nurse after graduation to fit herself for practical nursing in private families.

**Oxford Medical Publications: Manual of Medicine.**—By A. S. Woodward, M.M., M.R.C.P., Junior Curator of St. Bartholomew's Hospital Museum, etc., etc. Edinburgh, Glasgow, London and New York, (35 West 32nd Street, N. Y.)

The author of this work has aimed to give within the scope of 400 pages a summary of our present knowledge of medical diseases. It

is intended for the medical student and for a ready reference book for the medical practitioner. It includes chapters on "Diseases of the Alimentary System," "Diseases of the Kidneys," of "The Respiratory System," "The Blood," "Ductless Glands," "Constitutional Diseases," "The Nervous System," "Insanity," and "Acute Specific Fevers." It is an eminently practical work and, from personal experience in its use, the writer is able to commend it most highly not only for the concise form in which the facts are stated but also for the accuracy and completeness of the text.

**International Clinics:** A Quarterly of Illustrated Clinical Lectures and Especially prepared Original Articles on Treatment, Medicine, Surgery, etc., etc. By leading members of the Medical Profession throughout the World.—Edited by Henry W. Cattell, A.M., M.D. Volume IV. Twenty-second Series. Philadelphia and London: J. B. Lippincott Company.

This volume of *International Clinics* is especially rich in subjects relating to Medical Diagnosis and Treatment. Baumann's article on the Wassermann Test is a timely one and the importance of the author's conclusions should warrant their consideration by every medical practitioner. The article by Abrams on the treatment of exophthalmic goitre is of great practical interest. If the author is able to obtain the results he claims in a large percentage of cases, he has certainly made a valuable contribution to therapeutics. His claims for the value of spondylotherapy seem to be based upon sound therapeutic and clinical grounds and should receive serious consideration from every member of the medical profession. Eves' article on the enucleation of the tonsils and removal of adenoids by a simple method and Cumston's article on the indications for nephrectomy will, no doubt, prove of interest to those who are interested in surgical work.

**Pathfinders in Medicine.**—By Victor Robinson with a letter from Ernest Haeckel and an Introduction by Abraham Jacobi, New York Medical Review of Reviews.

This work has entitled a great deal of favorable comment among medical men and is an admirable work not only from the standpoint of the historic facts presented but also because of the interesting style in which these facts are related. The author has, in a series of fifteen essays, given the story of men who have been epoch makers in the history of medicine. It is one of the few works in the history of medicine that can be said in any way to measure up in literary style and polish to the standard which the subject requires. The author has endeavored to approach the subject from the standpoint of truth and fairness. In his dedication he says: "Nothing unworthy must be found in these pages; no unfair passage should be left within these covers.... I have written with careful hands and clean for I have sat near the Altar of the Temple of Truth." We accept these statements as being sincere and yet it is hard for us to understand how such a well informed writer as Dr. Robinson, approaching this subject with a desire to tell the whole truth and nothing but the truth should omit entirely any reference to Samuel Hahnemann in his work. There are few students of the history of medicine to-day who fail to recognize the revolutionary and far reaching effect of the writings of Samuel Hahnemann upon mod-



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ern medicine. In fact, it is doubtful whether the work of any single man, considered from both a positive and negative standpoint, has exercised more effect upon modern medical treatment than that of Hahnemann. We regret that this omission should, in our opinion, mar an otherwise excellent and commendable history of the great men of medicine.

**Principles and Practice of Obstetrics.**—By Joseph B. DeLee, A.M., M.D.

Professor of Obstetrics at the Northwestern University Medical School. Large Octavo of 1060 pages, with 913 illustrations, 150 of them in colors. Philadelphia and London: W. B. Saunders Company, 1913. Cloth, \$8.00 net; half morocco, \$9.50.

This treatise is intended both to supply the medical student with a brief and concise statement of the essential principles of obstetrics and also to supply the medical practitioner with such details of obstetrical procedures as will acquaint him with the various steps that must be carried out in handling a given case. To accomplish this purpose in a single volume, two sizes of type have been used. Less important matters and details of treatment and operations have been put in smaller type. The subject matter is divided into four parts: First, the Physiology of Pregnancy, Labor and the Puerperium. Second, the Conduct of Pregnancy, Labor and the Puerperium. Third, the Pathology of Pregnancy, Labor and the Puerperium. Fourth, Operative Obstetrics.

Considerable space is devoted to each of these subjects as the work contains over one thousand pages of quite large size. Not only is the text comprehensive, but it is thoroughly up-to-date and reliable. The book is remarkable for its illustrations of which there are 913. One hundred and fifty of these illustrations are in colors. Dr. DeLee has produced a work that we predict will soon occupy a foremost place in the literature of obstetrics and one which is well qualified to be a reliable source of practical information to medical students and practitioners of obstetrics.

**Oxford Medical Publications: The Treatment of Disease in Children.**—

By G. A. Sutherland, M.D., F.R.C.P., Physician to Paddington Green Children's Hospital, etc. London and 35 West 32nd Street, New York.

This volume is intended to serve as a practical guide to young practitioners in the treatment of diseases of infancy and childhood. The author has followed the policy of giving one full and definite line of treatment in preference to enumerating all of the methods of drugs that have been employed more or less successfully in the disease discussed. As the name of the book indicates, it is devoted entirely to treatment, and in the four hundred pages contained in the volume, the author has given a very rational and practical summary of the therapeutic management of diseases in children.

**Clinic of Orificial Surgeons.**—The spring clinic of the American Association of Orificial Surgeons will be held in the Surgical Amphitheatre of Hering Medical College, corner of Wood and York Streets, Chicago, Ill., April 23-4-5-6. Dr. E. H. Pratt, A.M., M.D., LL.D., and assistants will operate on clinical patients, demonstrating the funda-

oriental principles of Orificial Surgery as applied in the treatment of chronic diseases and as an adjunct to major surgery in general.

On April 26th, the fourth and last day of the clinic, Dr. Pratt and assistants will demonstrate other therapeutic measures which have been recently introduced to the medical profession; including abdominal calisthenics, manual therapeutics, high frequency treatment of internal organs, spondylotherapy and new hydro-therapeutic measures. These measures will be introduced and demonstrated not as curative measures within themselves alone, but as adjuncts to the ordinary armamentarium of the physician.

Tuition to this clinical course is free to all practicing physicians, medical students and nurses.

Physicians are invited to bring clinical cases for operation. No operating fee will be charged. Excellent hospital accommodations will be provided. Opportunity will be presented for the physicians bringing clinical cases to assist personally in the operation.

The clinic headquarters will be the Hotel La Salle, where reservations may be made in advance. For further information, address the Secretary of the Association:

W. A. Guild,  
Des Moines, Iowa.

**Denver Preparing for the Institute.**—All the homœopathic physicians in the United States and Canada should be interested in the coming meeting in Denver, of the American Institute of Homœopathy. The committee is now busy on the details of entertainment, and is making large preparation to show all the visiting doctors and their families a royally good time.

Denver is a beautiful city with many attractive environs, and in addition has the best summer climate in America. With the snow capped mountains, affording a constant delight to the eye, and the imagination, and the rushing, roaring streams, teeming with the gamiest fresh water fish, and the hundreds of varieties of beautiful flowers, and scenic grandeur not equalled anywhere else—Denver surely should be the objective point for the summer's vacation.

The committee is making all arrangements to give the visitors the best time ever experienced. They are planning mountain trips by auto and train, and working out every detail that will add to the pleasure and profit of the visitors. It is perhaps a bit incongruous to be planning where to go to be cool while we are so vigorously shoveling coal as at this time, but even this early we can begin to think of those scorching hot July days and the insufferable nights. So the cool breezes of Colorado, with the nights so cool that blankets must be used on the beds, is a big oasis in the long enervating summer.

You should plan to attend this session of the A. I. H. even if you are not a member. It will do you good to rub elbows with the other fellow and get the moss off your back and the cobwebs off your brain. If you are a member you surely must be on hand for this will be the biggest and best meeting ever enjoyed by the Institute.

**The New Vacule Package.**—A novel package is now being extensively advertised by the H. K. Mulford Company, of Philadelphia, as the "New Vacule Package." These "vacules" are vacuum containers especially employed for the prevention of deterioration in the activity of



potent drugs especially Digitalis, Ergot and Strophanthus. Careful investigations show that many preparations undergo changes, even when kept in tightly corked bottles, which result in a great loss of activity and thus render them unreliable as therapeutic agents. Only recently was it discovered, as the result of a series of experiments conducted in the Mulford Research Laboratories, that the changes to which the deterioration in these preparations is due, are caused primarily by the action of oxygen of the air which is held in solution in the liquid.

Further investigations show that with complete exhaustion and exclusion of air from the container and its contents, practical permanency may be secured, and in accordance with this, the H. K. Mulford Company have placed upon the market standardized preparations of Ergot, Digitalis and Strophanthus in "Vacules" (Vacuum Ampuls), which differ from ordinary "sealed ampuls" in that all the air is removed from the liquid contained in the vacules, which ensures permanency to the product.

**The New Treatment for Pneumonia.**—After long and laborious clinical study—extending, in fact, over a period of more than twenty months—Messrs. Parke, Davis & Co. announce the addition of Pneumonia Phylacogen to their list of therapeutic agents. This product is designed for the treatment of pneumonia or any infection caused by the pneumococcus. Administered in the early stage of the disease it is said to cut short the pneumonic process in a manner that is truly remarkable.

Pneumonia Phylacogen has been administered to patients of all ages and of many nationalities, with highly gratifying results in a large majority of cases. "From experience gained in the study of typical cases treated under favorable circumstances," one writer remarks, "we are led to believe that almost every case of pneumonia seen within the first twenty-four hours after the initial chill will recover if properly treated with Phylacogen." Another observer, a professor in one of the large American medical schools, pays the product a high compliment in these words: "Pneumonia Phylacogen is the only therapeutic agent in my experience that has ever shown a definite therapeutic action on the pneumonic process."

In view of the fact that pneumonia is one of the commonest and most fatal of infections (it is said upon good authority that it causes more deaths than tuberculosis, scarlet fever and small-pox combined), the new Phylacogen gives promise of a veritable therapeutic blessing.

**The Sophomore Class of the Hahnemann Medical College** have set a new standard in their knowledge of anatomy. Eight of the class passed the mid-year examinations with an average of 100 per cent. The average of the remainder of the class is also very meritorious.

The Faculty have decided to give a year of preparatory work which includes chemistry, biology, physics and a modern language other than English. Arrangements are being made to properly equip the laboratories for physics, chemistry and biology, and arrangements will be made to teach all of the subjects to students who are deficient in these requirements. This plan puts the Hahnemann on an equal footing with medical departments of universities, as it will enable the students who are deficient in one or more of these subjects to obtain a preliminary training with a special view of studying medicine, and if they are deficient in only a small amount of this preliminary work, they will

have an opportunity of completing their requirements and continuing the work of the freshman year. The curriculum will conform to the highest requirements of the State Board of Licensure, and will be subject to the suggestion and criticism of the medical profession at all times. It is a well-known fact that the average student who enters the medical department is not scientifically trained to pursue the work to the best advantage. Many of them are deficient in a practical knowledge of physics and chemistry, and some even in the fundamentals of mathematics. The study of a modern language other than English is of obvious value, and we are fortunate in having a teacher who has taught both French and German in a college of high standard. The full details of the curriculum and the number of hours devoted to each study will be presented in due time. It is very important to enroll not only a large freshman class who have the required knowledge of chemistry, biology, physics and a modern language, but also a considerable number of students for the first year of preparatory work. The Alumni of the Hahnemann should be proud that their college has not only met the rigid requirements of the State Board of Medical Licensure, but have anticipated further advances, and will be prepared next year to give a complete preliminary year in addition to the four-year course that is now required, and the optional year as interne in the hospital. It is well-known that all our students take advantage of the hospital facilities and our close connection with several of the leading hospitals of Philadelphia render it easy for any of our graduates to obtain excellent appointments.

The State Board of Medical Licensure inspected the college on February 13th, and were very well pleased with the equipment and methods used in teaching. As will be remembered, Dr. Baldy, President of the State Board of Medical Licensure paid the college a remarkable tribute at a previous inspection, when he said, in substance, that the facilities for teaching in our college were better than any in the State of Pennsylvania.

A cordial invitation is extended to all who are interested in the college to see the equipment and methods used in teaching. Visitors uniformly commend the exceptional advantages that we give to our students.

Interest in the Hahnemann Institute has been revived and a somewhat different policy has been pursued this year than in previous years. Prominent members of the Faculty have contributed to the program and at the January meeting Dr. Stewart delivered an admirable address upon "Medical Ethics." Dr. Nagel and his sister effectually demonstrated their musical ability in the exquisite rendering of several violin and piano duets.

**New Castle County Homœopathic Medical Society of the State of Delaware Visits Hahnemann Medical College and Hospital, Philadelphia.**—In response to an invitation extended by Doctor Wm. B. Van Lennep, Dean of the Hahnemann Medical College and Hospital of Philadelphia, almost the entire membership of New Castle County Homœopathic Medical Society, of Wilmington, Delaware, visited the Hahnemann Medical College and Hospital on February 13th, 1913. The invitation was extended by Doctor Van Lennep while a guest of honor at the annual banquet of the New Castle County Homœopathic Medical Society, held at the Hotel Du Pont, Wilmington, Delaware, on January

# Fellows' Syrup of Hypophosphites

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## NOTICE—CAUTION

The success of Fellows' Syrup of Hypophosphites has tempted many to offer imitations of it for sale.

As these cheap and inefficient substitutes are frequently dispensed instead of the genuine preparation, Physicians are earnestly requested when prescribing the Syrup, to write "**Syr. Hypophos. FELLOWS**".

As a further precaution, it is advisable that the Syrup should be ordered in the original bottles; the distinguishing marks which the bottles (and the wrappers surrounding them) bear can then be examined, and the genuineness—or otherwise—of the contents thereby proved.



3rd, 1913. The invitation having been extended to the society because of Doctor Van Lennep's desire to have the members of the New Castle County Society personally go over the institution, and see the wonderful change, and the remarkable improvements which the institution has undergone during the past three years.

A number of the teaching staff were present to assist the Dean in showing the doctors through the college and hospital.

Without any dissension the entire society was high in its praise of the remarkable work which the institution is doing, and are more firmly convinced than ever that "Old Hahnemann" of Philadelphia, is considered the best Homœopathic Medical College in the world.

Among the distinguished doctors present from Wilmington were: Doctors I. M. Flynn, L. W. Flynn, J. Paul Lukens, H. W. Howell, J. P. Adair, E. S. Bullock, H. A. Pennock, Frank S. Pierson.

### PENNSYLVANIA STATE NOTES FOR MARCH 1913.

The Germantown Homœopathic Medical Society, held its regular monthly meeting at the "Continental Hotel," Ninth and Chestnut Streets, on Monday, February 17, 1913, at 9 P. M. Doctor Ralph Bernstein gave "A Projectoscopic Skin Clinic—A Lantern Demonstration of the More Common Skin Diseases (in colors)—Their Recognition and Treatment," which proved to be a very interesting feature of the occasion. The Censors reported the name of Doctor G. Harlan Wells, Hahnemann, 1902, who was elected to membership. There was a full attendance of members, and a delightful time was had by those present.

Landreth W. Thompson, M.D., Secy.

The Clinico Pathologic Society of Philadelphia, held its regular monthly meeting at Hahnemann College, Saturday evening, February 15, 1913, at 8.30 P. M. The scientific program consisted of the following:

"Pathology of, and Demonstrations of a Case of Kerato-conus," Dr. F. O. Nagle; "Sitis Inversus Viscerum" (Presentation of a case), Dr. C. D. Saul; "Clinical Analysis and Pathologic Findings of an Unusual Case," Dr. C. D. Fox; (Discussion opened by Dr. B. K. Fletcher); "Repair of a large Leutic Perforation of the Palate" (with photographs), Dr. G. W. MacKenzie.

The meeting proved to be a very enjoyable one, and was well attended.

Benj. K. Fletcher, M.D., Secy.

The Homœopathic Medical Society of the County of Philadelphia, held its regular monthly meeting at Hahnemann Medical College, Thursday, February 13, 1913, at 8.30 P. M. The scientific program consisted of the following:

"Progressive Homœopathy," F. McN. E. Howell, M.D., Reading, Pa.; "The Homœopathist and Modern Medicine," Weston D. Bayley, M.D., Philadelphia.

The meeting was full of interest, and was well attended.

Wm. M. Sylvis, M.D., Secy.

The Philadelphia Society for Clinical Research, held its regular monthly meeting at the office of Doctor W. Snyder, 5300 Spruce Street, on Monday, February 24th, 1913, at 9 P. M. A very interesting paper

was read by Doctor James, which was well presented. A large number of members were present, and an enjoyable time was had by those attending the meeting.  
Percy A. Tindall, M.D., Secy.

**The Homœopathic Medical Society of the 23rd Ward of Philadelphia,** held its regular monthly meeting at the office of Doctor E. Humphreys, 1925 North 32nd Street, on Wednesday, February 19, 1913. A paper on "Mastoiditis" was read, and was very interesting. A very enjoyable time was had by a large number of members who were present.  
John D. Boileau, M.D., Secy.

**The Hahnemannian Institute,** held its regular monthly meeting on Wednesday, March 5, 1913, at 8 P. M. "Medical Law," the subject for discussion, was heartily entered into by a large number present. E. Clinton Rhodes, LL.D., was the speaker of the evening. A very delightful musical program was also enjoyed by those present.

**The West Jersey Homœopathic Medical Society,** held its winter meeting at the West Jersey Homœopathic Hospital, Camden, on Wednesday, February 19th, at 1 P. M. Papers read were as follows:

"Homœopathic Pride." Dr. F. F. Moore; "Suggestions to the General Practitioner on the Subject of Acute Middle Ear Inflammation," Dr. G. W. MacKenzie; "A Good X-Ray Equipment for a Hospital with Demonstrations," Dr. Walter C. Baker; "Some Hints how Hahnemann Discovered the Relationship of Temperament to the Disease," Dr. A. S. Ironside; "The Use of Obstetric Forceps," Dr. W. J. Barrett.

Doctor O. S. Haines read a paper which was very interesting, and well presented.  
T. E. Parker, M.D., Secy.

In connection with the plans laid for donation day at the Women's Homœopathic Hospital, Twenty-second Street and Susquehanna Avenue, the new building which has been erected as a home for nurses was opened on February 18th, and as an added feature to the elaborate program an X-Ray machine of the most modern invention was installed. It is the first of its kind to be used in a hospital in this city. Tours of inspection were conducted by the Board of Managers of the hospital between 10 A. M. and 5 P. M., for the purpose of showing the need of financial assistance in the maintenance of the institution.

**Members of the Bureau of Medical Education and Licensure** made an inspection of Hahnemann Medical College and Hospital on Thursday afternoon, February 13th, at 3 P. M. All members of the teaching staff were present and assisted in showing the guests about the college and hospital, explaining the workings of the same, the committee being highly gratified with the institution in general.

**Personals.**—Mr. and Mrs. Thomas J. Budd announce the marriage of their daughter Anna Burwell to Dr. John Percy Craig, on Wednesday, the twenty-sixth of February, nineteen hundred and thirteen, Philadelphia. At home, Wednesday evening, April twenty-third, from eight until ten oclock, 427 East Broad Street, Chester, Pa.

Dr. Harry Frederick Hoffman and Miss Ruth Virginia Peabody, announce their marriage on Tuesday, the fourth of March, One Thous-

and nine hundred and thirteen, Westerly, Rhode Island. At home after the fifteenth of March. Allentown, Pa.

Dr. J. W. Frank announces the removal of his office from 114 No. 17th Street to 2037 Chestnut Street, Philadelphia.

Dr. Charles T. Abbott announces the removal of his office to 1825 Chestnut Street, Philadelphia. "Eye and Ear."

Dr. Chauncey V. B. Vedder announces the removal of his office to 5731 Baltimore Avenue, Philadelphia, Pa.

The many cases of nasal and naso-pharyngeal inflammation which are so prevalent at this season, call to mind the fact that Glyco-Thymoline is almost a specific in their treatment.

The cooling, soothing and slightly anodyne effect of this preparation on the dry and hot mucous surfaces is well known to the profession. In addition Glyco-Thymoline will, by its exosmotic properties, relieve the congested area of the inflammatory exudate and by stimulating the capillaries to renewed activity, bring about a normal condition of the parts.

**The Homœopathic Medical Society of the County of Philadelphia**, held its regular monthly meeting Thursday evening, March 13th, in the Elkins Memorial Clinical Amphitheatre of the Hahnemann Hospital. Dr. William Francis Honan, of New York, read a paper on the intravenous method of administering the ether; Dr. J. Wyllis Hassler, of New York, demonstrated the technique of the intravenous administration of ether on a case of hemorrhoids and a case of fracture of the patella, Dr. Wm. B. Van Lennep operating both cases while under the anæsthetic. All present were deeply impressed with the rapidity with which ether produced complete anæsthesia when given by the intravenous method and by the general satisfactory results attending this method of anæsthesia.

**The Western Pennsylvania Auxiliary of the Alumni of Hahnemann Medical College, of Philadelphia**, held its second annual meeting and banquet on Friday, February 14th.

The meeting was held in the Library of the Homœopathic Hospital, Pittsburgh, Friday afternoon, about twenty-five alumni being present.

The following officers were elected: President, Dr. J. H. McClelland, Pittsburgh; first vice-president, Dr. C. C. Rinehart, Pittsburgh; second vice-president, Dr. J. M. Maurer, Washington; third vice-president, Dr. I. D. Metzgar, Tyrone, Pa.; secretary, Dr. C. W. Sample, Wilkinsburg, Pa.; treasurer, Dr. W. B. Boggess, Pittsburgh, Pa.; executive member, Dr. George B. Moreland, Pittsburgh.

The banquet was held at the University Club, Friday evening and was attended by about fifty alumni from Western Pennsylvania.

Dr. Wm. B. VanLennep, the Dean of Hahnemann and Dr. Ralph Bernstein were present as representatives of the College Faculty.

Dr. William J. Martin acted as toastmaster.

Drs. Van Lennep, W. F. Edmundson, J. H. McClelland, H. S. Nicholson and S. M. Rinehart responded to formal toasts, while Dr. Bernstein and many others responded when called upon by the toastmaster.

A very pleasant evening was spent and much enthusiasm aroused for old Hahnemann.

G. B. M.



# THE HAHNEMANNIAN MONTHLY NEWS AND ADVERTISER

A Medical Newspaper

APRIL, 1913

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**London Medical Publications: The Diseases of the Skin.**—By Willmott Evans, M.D., B.S., B.Sc., F.R.C.S., Surgeon to the Royal Free Hospital, etc., etc. With thirty-two illustrations. London: University of London Press. New York Agency: 35 West 32nd Street, N. Y.

This work is intended to serve as an introduction to the study of diseases of the skin and the descriptions have been written in as simple a style as is compatible with accuracy. The author believes that one reason why so many students and practitioners fail to obtain satisfactory knowledge of dermatology is, that many of the standard treatises on the subject are too voluminous and technical for those who are just entering upon its study. In the present volume we find the various diseases are taken up *seriatim*. The diagnostic, prognostic and therapeutic features are briefly but clearly described. The style of the text is practical and concise. Our only unfavorable criticism of the work would be to say that the illustrations are rather poor and not so numerous as we would expect in a new work on dermatology.

**Oxford Medical Publications: The Surgery of the Skull and Brain.**—By L. Bathe Rawling, F.R.C.S., Surgeon, with charge of out-patients St. Bartholomew's Hospital, etc., etc. London: Henry Frowde, and Hodder and Stoughton. New York Agency, 35 West 32nd Street, N. Y. Price \$6.00 net.

This work is based upon careful research and wide experience on brain surgery, carried out by the author during the past ten years. The first chapter is devoted to the subject of Cerebral Topography, following this we have chapters on the Technique of Portions of the Skull and Brain, Fractures of the Skull, the Effects of Head Injury, Tumors of the Brain, Infective Diseases of the Brain and Meninges, Bullet-Wounds of the Brain and Skull, Trigeminal Neuralgia. No pains have been spared by the author to obtain and to present the most recent

information available on this very important and growing subject. The typography of the book is unusually fine, the text being printed in large type and the illustrations being numerous and of an unusually fine character. It is a work that is necessary to neurologists and surgeons who desire the latest information on the subject of which it treats.

**Health and Longevity Through Rational Diet.**—By Dr. Arnold Lorand, Carlsbad. F. A. Davis, Publishers, Philadelphia, Pa., 1912. Price, \$2.50.

This subject is one that has attracted the earnest attention of both the profession and the laity. At a matter of fact, the preservation of health and the prolongation of life is the ultimate aim of all medical science and the progressive physician is ready to welcome any practical suggestions along this line.

Dr. Lorand has been in active practice for many years at Carlsbad and has had ample opportunity to observe the harmful consequences of faulty nutrition. We are glad to note that the Doctor is not an advocate of any special fad or system of feeding. He believes that the food must be adapted to the particular needs and occupation of the individual and that, because overeating is harmful in some, it is not necessary for others to restrict their diet to such an extent that failure of nutrition results. His views as to the importance of mineral salts in an ideal diet is well worthy of consideration.

In the 406 pages of which he devotes to the subject, the author has covered it in every detail. Any physician who desires to have the most complete and up-to-date information on this important subject at his disposal, should avail himself of the first opportunity to read Dr. Lorand's work.

**Nervous and Mental Diseases. For Students and Practitioners.**—By Charles S. Potts, M.D., Professor of Neurology in the Medico-Chirurgical College of Philadelphia. New (third) edition, enlarged and thoroughly revised. In one 12mo volume of 610 pages, with 141 engravings and six full-page plates. Price, cloth, \$2.75 net. Lea & Febiger, Publishers, Philadelphia and New York, 1913.

Diseases of the Mind and Nervous System are among the most intricate and difficult of comprehension of all subjects in medicine, and yet the general practitioner, who probably has not devoted special study to this department, is almost invariably the one who first meets these cases and refers them to the alienist. A medium-sized work, short, clear, and to the point is therefore a great desideratum, and this has been shown in the demand which has brought Professor Potts' book to its third edition. In this new revision the chapter on general symptomatology and methods of examination has been amplified. A description of tic embodying the present-day view of that disorder, and short descriptions of myotonia atrophica, progressive lenticular degeneration and dysbasia lordotica deformans have been added. The importance of the examination of the cerebrospinal fluid and determination of the existence of the Wassermann reaction in the diagnosis of certain diseases of the nervous system has been realized and the latest views incorporated. In brief, the work includes the most recent advances. It is extremely well illustrated; and a better book for the purposes of the general practitioner or for the college student would be hard to find.

# American Institute of Homoeopathy

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SESSION OF 1913

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*Denver, July Sixth to Twelfth*

## Preliminary Announcement of the Transportation Committee

The Board of Trustees having selected Denver as the place of meeting for the session of the Institute for 1913, the Transportation Committee has conceived it to be its duty to try to make the journey to the "Magic City of the Plains" as pleasant and comfortable for the members as possible. With this end in view, and to give them a different route from the one taken on the way to Pasadena, the Committee has this year selected the

**Chicago and North Western Ry.—Union Pacific R. R.**  
as the Institute's Official Route to Denver.



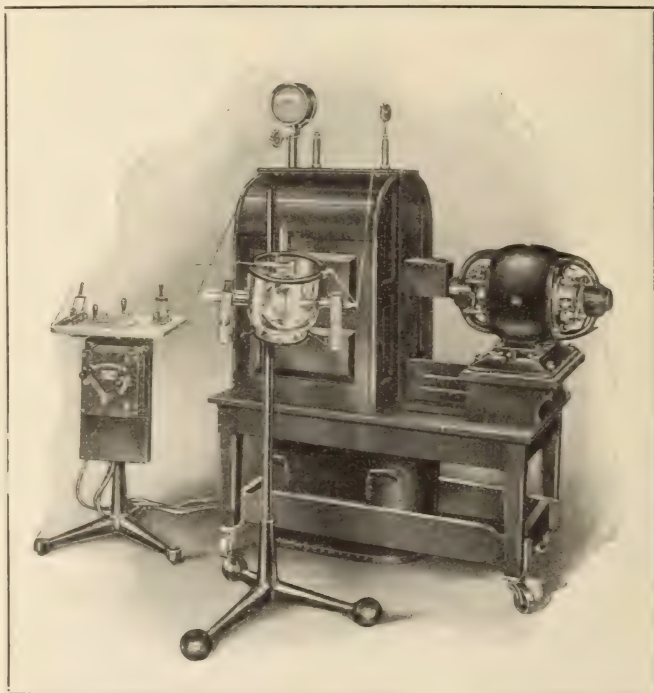
DOUBLE-TRACK SCENE ON C. & N. W. RY.

The Chicago and North Western Ry. is well-known as one of the very highest class of roads leading out of Chicago. It is double-tracked all the way to Omaha, and is protected with the latest automatic safety signals. Its equipment is of the highest order, its dining car service unsurpassed for excellence of cuisine and appointments, its motive power is equal to that of any line in the country, and its splendid new



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Are you using every aid in your diagnosis work?

Ask us about our apparatus and our methods. We are the originators of reliable X-ray apparatus.

There are many imitations, but none its equal. We compete in quality but not in price.

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### **Palatial Passenger Terminal in Chicago**

is the last word in railway station accomplishment.

The Union Pacific System from Omaha to Denver is also a model in railway construction. As far west as Julesburg, across the Colorado-Nebraska line, it is double-tracked, ballasted with the famous Sherman gravel and is made safe by a system of automatic block signals. The Union Pacific was the Pathfinder for railways across the continent in the days of the Indian and the buffalo. Under the splendid genius of Harriman it was made the first road of the country beyond the Missouri and is to-day the Standard road of the West. All that can be said for the Chicago and North Western as the initial road of the itinerary from Chicago is applicable to the Union Pacific from Omaha to Denver.

### **The Institute's Special Trains.**

For this session the Institute will have its own special train or trains and will go from Chicago as one large family party. All who went to California will recall the enjoyments of that excursion. The Special for this year will be a counterpart of that. We are to have our own exclusive train, of the very latest Pullman designs, supplied with every modern convenience and comfort, our own diners to serve members of the Institute promptly. Special railway attendants to look after our comfort will also accompany the train, and the Transportation Committee will be aboard to serve the members at their demand. It is believed this excursion will be one of the most enjoyable in the history of the Institute, and thus early, all indications point to a record-breaking party.

### **Early Applications.**

Paraphrasing an ancient proverb: "The Early Bird Will Get the Soft Berth," Dr. T. E. Costain, 29 East Madison Street, Chicago, will attend to the details of locating prospective members of the excursion in the cars and berths or staterooms of their selecting. In this he will be courteously assisted by Mr. H. A. Gross, General Agent Passenger Department, of the Chicago and Northwestern Ry., at 148 S. Clark St., corner of Adams Street, and G. W. Vaux, General Agent, Passenger Department, Union Pacific System, 112 W. Adams Street, Chicago, Ill.

For Philadelphia and that section like service will be performed by the member of the committee for the East, Dr. G. Harlan Wells, 1807 Chestnut Street, and by the representatives of the Chicago and North Western Ry., Mr. D. M. Davis, 1020 Chestnut Street, and the Union Pacific R. R., Mr. S. C. Milbourne, 841 Chestnut Street.

For New York and vicinity, Dr. John B. Garrison, 616 Madison Avenue, has been impressed by the Committee for like attention, while

For New England, Dr. DeWitt G. Wilcox, 419 Boylston Street, Boston, Mass., has kindly consented to get up a New England Gazette car or two as far West as Chicago, there to join the "Institute Special" to Denver.

### **Rates and Conditions.**

The usual Colorado Summer Tourist rate of Thirty Dollars (\$30.00) for the round trip, good for three months, from Chicago to Denver and return, will be available for the Institute, as for all the conventions that meet in Denver during the summer, of which there are a large number. We are in on the ground floor in this particular.

By availing ourselves of this three-months' ticket members of the Institute who may wish to summer in Colorado, or to go farther west for vacation purposes, can return at their pleasure, and over the road of their choice, at any time within ninety days. Already a good number are indicating a desire to spend their vacation this year in the Glorious Rockies.

**Day and Date of Start.**

At this time it is expected the departure from the magnificent Chicago and North Western Passenger Terminal at Chicago, will be made on the morning of Saturday, July 5th, in order to arrive in Denver in time for the Memorial Service set for the evening of Sunday, July 6th. In order to accommodate incoming members from the East, and those from the vicinity of Chicago, who will arrive in that city on the morning trains, it is expected we will leave Chicago about 10 or 10.30 o'clock in the forenoon. All of the second day will be spent in running across the plains and prairies of Nebraska and Colorado, famous in history as the Pathfinder's Trail to the Rockies.



BIRDSEYE VIEW OF DENVER, COLO.

**Illustrated Booklet.**

A little later the Transportation Committee and the Official Line will tender the members of the Institute an illustrated booklet setting forth at greater length, and more in detail, the pleasures and benefits to be derived from attendance upon the Institute at the Denver session. Meanwhile it is hoped members will make early engagements from the Committee who have been named, or direct from Mr. H. A. Gross, General Agent, Passenger Department, Chicago and North Western Railway, 148 South Clark Street, Chicago; or G. W. Vaux, General Agent, Passenger Department, Union Pacific System, 112 West Adams Street, Chicago.

C. E. FISHER, M.D., Chairman.



**Ready for Distribution.**—"Carbohydrates in Infant Feeding" is now being mailed to every physician in the United States whose address is given in the national directories. Physicians who have recently changed their location or whose address does not appear in the professional directories may secure a copy of this brochure upon request, as a certain number of extra copies will be held for a brief period in order that no one may be disappointed.

Please make request promptly.

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Boston, Mass.

**Convalescence from the Exanthemata.**—The first two or three months of the year are usually characterized, in the experience of the family physician, by the occurrence in his practice, of a crop of cases of the contagious diseases of children, especially scarlet fever, measles, German measles, etc. This is accounted for by the readiness with which contagion is spread in the schools, when ventilation of the school room is the least perfect and the closer housing of school children during school hours favors the distribution of communicable diseases. As the diseases in question are self-limited in nature, expectant and symptomatic treatment, together with precautions as to isolation, etc., is about all the physician is called upon to direct. It is well known, however, that in all but the mildest cases, the adolescent subject of scarlatina, or measles, is usually more or less debilitated or devitalized, when convalescence is established. Special care should be taken to avoid the administration of any tonic or reconstituent which is likely to disturb the child's digestion or, by inducing constipation, to minimize the appetite or desire for food.

Pepto-Mangan (Gude) is the ideal reconstructive tonic for these young patients, because it is pleasant to the taste, easily tolerable by the stomach and readily assimilable by blood and tissue and promptly efficient in restoring appetite, strength, color and general well-being.

**Alumni Association Meets.**—The third annual meeting and banquet of the Northeastern Pennsylvania Auxiliary Alumni Association of the Hahnemann Medical College, of Philadelphia, Pa., was held at Hotel Casey, Scranton, Pa., on April 12, 1913.

Dr. H. L. Northrop, of Philadelphia, conducted a clinic at the Hahnemann Hospital in the afternoon, and was the guest of honor at the banquet in the evening.

Dr. J. L. Peck, retiring president, was toastmaster. Everyone present expressed deep interest in the welfare and future of our Alma Mater.

A most pleasing feature of the evening was the presentation of a loving cup to Dr. H. B. Ware, from his "Doctor Friends" of Scranton. Dr. R. V. White made the presentation speech.

Officers elected for the ensuing year were: President, Dr. F. W. Roberts, Plymouth, Pa.; vice-president, Dr. A. F. Merrill, Hallstead, Pa.; secretary and treasurer, Dr. H. F. Heilner, Scranton, Pa.; executive member, Dr. T. M. Johnson, Pittston, Pa.

Those present were: Dr. H. L. Northrop, Philadelphia, Pa.; Dr. F. D. Thomas, Wilkes Barre, Pa.; Dr. R. G. Long, Wilkes Barre, Pa.; Dr. F. W. Roberts, Plymouth, Pa.; Dr. W. W. Preston, Montrose, Pa.; Dr. A. F. Merrill, Hallstead, Pa.; Dr. T. M. Johnson, Pittston, Pa.; Dr. M. C. Johnson, Pittston, Pa.; Dr. J. L. Peck, Scranton, Pa.; Dr.

H. B. Ware, Scranton, Pa.; Dr. H. L. Vail, Scranton, Pa.; Dr. Anna C. Clark, Scranton, Pa.; Dr. G. J. Berlinghof, Scranton, Pa.; Dr. G. M. DeWitt, Scranton, Pa.; Dr. A. P. Gardner, Scranton, Pa.; Dr. Theodore Sureth, Scranton, Pa.; Dr. R. V. White, Scranton, Pa.; Dr. H. F. Heilner, Scranton, Pa.; Dr. J. N. Douglas, Scranton, Pa.; Dr. S. Friedmann, Scranton, Pa.

The meeting adjourned to meet in Wilkes Barre, Pa., in 1914.

Dr. H. F. Heilner, Secy.

The Curriculum Committee of the Cleveland-Pulte Medical College institutes for the coming year additional entrance requirements. A year of college work is required which shall include general biology, general chemistry, and one language other than English. Following the four years' college course, a year of hospital experience will be required. This is in line with the recommendations adopted by the newly formed College Alliance which resulted from the suggestions made by President Hinsdale to the Board of Trustees of the Institute at their December meeting.

H. L. Frost,

Chairman of Committee.

#### A COMMUNICATION.

Camden, N. J., April 16, 1913.

Editor of the "Hahnemannian Monthly":

I have been told recently that a certain party in Philadelphia is "exploiting" a Mexican mining property (**and scheme**) almost exclusively among physicians (and more particularly Homœopathic). As I happen to know about this party and some of his past "doings" I would just like to give you a hint for the benefit of your readers. To them you might whisper (paraphrasing an old, old saw) **"If you would be done by, as he has done others, keep on letting him do you"** out of your hard-earned (no, I mean **hard collected**) little dollars, thus helping him in his "little game" of **"doing unto himself, by doing others."**

A "done investor."

**Obituary.**—Dr. E. D. Doolittle died at his home at Easton, Pa., on May 10th, 1913. Dr. Doolittle was a son of the late Rev. Horace and Sarah Wadsworth Doolittle, and was born in Key West, Fla. He was the last of his family, several brothers and sisters having preceded him in death. On his mother's side, Dr. Doolittle came from the Wadsworth family, which has been in this country for 270 years, and whose family tree indicates a clearly traced origin to the twelfth century. Dr. Doolittle's father was a Baptist clergyman, who came from New Lebanon and was a boy with Samuel Tilden. Dr. Doolittle was educated at Madison University, now Colgate, and in 1870, he graduated from Bellevue Medical College, in New York. He first settled in Brooklyn and at one time took up the study of gynecology in the New York Polyclinic. He gradually worked into the Homœopathic school of practice, and for a number of years, was actively engaged in a large practice in this city.

In 1881 he helped to organize the Lehigh Valley Homœopathic Society. He was its first vice-president, then its president, and for seven years was its secretary. He was also a member of the State Homœopathic Society, and frequently contributed to the medical press. In 1880, he became a member of the Royal Arcanum, and was made medical examiner that year. He was elected a representative to the Grand Coun-

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oil in 1887, and again in 1889, without solicitation on his part, was elected at Chambersburg as G. V. R., and in 1893, unanimously elected grand regent for the ensuing two years. He was grand instructor in the Home Circle, but refused promotion. He had attended the Grand Lodge Knights and Ladies of Honor, the Supreme Council, I. O. H., and the Supreme Commandery K. of M. He was president of the Heptasoph Association. For a number of years, Dr. Doolittle was deacon and treasurer of the First Baptist Church, this city.

Dr. Doolittle married Miss Julia F. Ludlam, of New York City, in 1871, and they had two sons. His second wife was Miss Catharine Riddle, of New Hampton, N. J.

**Personals.**—Dr. Walter R. Iszard, Hahnemann, 1902, has been appointed Genito-Urinary Surgeon to the Cumberland Street Hospital, Brooklyn, N. Y.

**Practice For Sale.**—An established practice, located in a growing neighborhood in West Philadelphia, situated near corner of a main Street, will be given away free for price of residence and office fixtures, including X-Ray and High Frequency apparatus, etc. Reason for selling—going to specialize. Address: F. H. A., care of "Hahnemannian Monthly."

#### PENNSYLVANIA STATE NOTES

The Homœopathic Medical Society of the County of Philadelphia, held its regular monthly meeting in the Elkins Memorial Clinical Amphitheater of Hahnemann Hospital, on Thursday evening, March 13, 1913, at 8.30 P. M. The scientific program consisted of the following:

"The Intravenous Method of Administering Ether"—Wm. F. Honan, M.D., New York; "Demonstrations of the Intravenous Administration of Ether"—J. Wyllis Hassler, M.D., New York; "Operations upon Cases Intravenously Etherized"—W. B. Van Lennep, M.D., Philadelphia.

Great interest was shown at the meeting by a large number of members present.

W. M. Sylvis, M.D., Secy.

The Goodno Homœopathic Medical Society held its first meeting for 1913 at the Bolton House, Harrisburg, April 10th. There were fourteen members present. After a banquet at which the Society were the guests of the Dauphin County members the following interesting papers were presented. First was inaugural address by the president, Dr. R. L. Perkins, of Harrisburg. Dr. J. Roas Swartz, of Harrisburg, gave a very interesting talk on La Grippe, which brought out a free discussion. The last paper, presented by Dr. H. H. Rhoads, of Middletown, on the "Treatment of Diabetes Mellitus," was well prepared and enjoyed by the Society.

W. E. J. Bomberger, Secy.

The Clinico Pathologic Society of Philadelphia, held its regular monthly meeting at Hahnemann College, Saturday evening, March 15, 1913, at 5.30 P. M. The papers read were as follows:

"Purulent Pericarditis"—O. H. Paxson, M.D.; "Demonstration of the Organism of Sleeping Sickness"—George A. Hopp, M.D.; "Studies in Giant Cell Sarcomas"—J. D. Elliot, M.D.; "Multiple Septic Arthritis Complicating Pregnancy"—F. J. Frosch, M.D.

Several interesting Clinical Cases were presented, and much inter-

est was shown at the meeting by a large number of members who were present.

Benj. K. Fletcher, M.D., Secy.

**The Germantown Homœopathic Medical Society** held its regular monthly meeting at the Union League, Broad and Sansom Streets, on Monday, March 17, 1913, at 9 P. M. A paper for discussion was presented by Doctor Percy H. Ealer, the title being: "The Problem of the Social Evil-So-Called," which proved a very interesting feature of the occasion. There was a large attendance of members, and a delightful time was had by those present.

L. W. Thompson, M.D., Secy.

**The Women's Homœopathic Medical Association of Pittsburgh, Pa.,** held its regular monthly meeting at the office of Doctor Anna D. Sarnier, 616 Wood Street. A paper on "Acute Gastritis," was read by Doctor Jane N. Gilliford, of Pomeroy, O., and was enjoyed by all present. Doctor Mary E. Coffin gave a review of the remedies most often indicated in Acute Gastritis which proved very interesting. Doctor Ellen Walker delivered some very interesting remarks upon the subject of "Anaesthesia." The meeting was well attended and was enjoyed by all present.

Lydia B. Pierce, M.D., Secy.

**The Homœopathic Medical Society of Delaware County,** held its regular monthly meeting in the Staff Room of the J. Lewis Crozer Hospital, Chester, Pa., on Thursday, March 20, 1913, at 3.30 P. M. Doctor Oliver B. White, of Hahnemann Maternity Hospital, read a paper on "Abortion," which was well presented, after which the members viewed the new X-Ray outfit of the hospital which was on exhibition. The meeting was an interesting one, and was well attended.

G. C. Webster, M.D., Secy.

**The Homœopathic Medical Society of the 23rd Ward of Philadelphia,** held its regular monthly meeting at the office of Doctor M. D. Faunce, 1217 E. Susquehanna Avenue, on Wednesday, March 19, 1913. An interesting paper on "Diphtheria" was read and enjoyed by all present. There was a full attendance of members, and the meeting was full of interest.

John D. Boileau, M.D., Secy.

**The Women's Homœopathic Medical Association, of Pittsburgh, Pa.,** held its regular monthly meeting at the office of Doctor Anna Johnston, 5016 Liberty Avenue, Pittsburgh, Pa., on Thursday, April 3, 1913, at 8 P. M. Doctor Johnston read a paper on "Pneumonia," which was very interesting, and was well presented, after which a hearty discussion was entered into. A large number of members was present, and an enjoyable time was had by those present.

Lydia B. Pierce, M.D., Secy.

**The Philadelphia Society for Clinical Research** held its regular monthly meeting at the office of Doctor Percy A. Tindall, 1613 South Broad Street, on Monday, March 24, 1913. Some very interesting papers were read, and enjoyed by all present. There was a full attendance of members, and a delightful time was had by those present.

Percy A. Tindall, M.D., Secy.

**The Homœopathic Medical Society of Chester, Delaware and Montgomery Counties,** held their "Hahnemann Birthday Celebration" on Tuesday, April 8th, 1913, at Chester, Pa., in the Y. M. C. A. Building, at

1.30 P. M. The Hahnemann address was made by Augustus Korndoerfer, M.D., who handled the subject in a very able manner. A talk on "Aural Diseases," with lantern slides, was given by Doctor Gilbert J. Palen, which proved to be a very interesting feature of the occasion, after which the members were entertained by the Physical Director, Carl B. Sanford, who gave some very interesting demonstrations. The Annual Planked Delaware River Roe Shad Dinner was then served to all present, and was thoroughly enjoyed by all members.

Isaac Crowther, M.D., Secy.

**Hahnemann Fiscal Report.**—The twenty-seventh annual meeting of the Hahnemann Hospital Association was held at the Bellevue-Stratford, on March 12, 1913. Miss I. Semple acted as president pro tem. The report of the general treasurer, Charles Perkins, showed returns from patients treated in the wards of the hospital during the past year amounting to \$6,000, and from those occupying private rooms \$49,000. The corresponding secretary reported several donations from private individuals. Addresses were delivered by Bishop Garland, Doctor W. W. Speakman and Doctor Gilbert J. Palen.

**House Votes to Require One Year's Service as Hospital Interne.**—The amendment to the Medical Licensure Act, providing that all graduates must serve one year as internes in hospitals before taking State examination, was passed on April 1, 1913, at Harrisburg, Pa., in the House 127 to 47. Doctor Newbaker Montour said the idea was to protect the State from Medical Colleges which have less stringent requirements than Pennsylvania institutions.

**Five Year Course for Medical Students.**—Hereafter, students in schools belonging to the Association of American Medical Colleges will be forced to take a five-year instead of a four-year course as at present. A resolution to this effect was adopted at the closing session of the Association at Chicago, on February 26, 1913.

There are now thirty colleges which enforce a two years' collegiate course preparatory to admittance to a medical college, and five others have adopted the same rule, effective January 1, 1914. The resolution as adopted raised the entrance standard for all the colleges in the Association, after January 1, 1914, to include a year of college work in physics, chemistry, animal biology and a modern language.

**Facts About Phylacogens.**—Practitioners who have a fondness for figures, and who want definite, first-hand knowledge of what the Phylacogens are accomplishing in the way of actual clinical results, are urged to turn to the display announcement in the current issue of this journal bearing the signature of Parke, Davis & Co. Here, under the title "The Value of the Phylacogens," one finds the results in 4,148 cases of infectious disease that have been treated with Phylacogens. One also reads in detail what is credited to each individual Phylacogen. For instance, you may be interested in rheumatic affections. You see at a glance that a certain number of cases have been treated and reported; the same glance tells you how many of them were treated successfully. This is equally true of pneumonia cases, erysipelas cases, gonorrheal cases, mixed-infection cases. Figures are apt to be tiresome. These figures are not so; they tell what every practitioner of medicine wants to know or should know. We commend the announcement to our readers.



# THE HAHNEMANNIAN MONTHLY NEWS AND ADVERTISER

A Medical Newspaper

MAY, 1913

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**Oxford University Publications: Medical Diseases of Children.**—By T. R. C. Whipham, M.A., M.D., (Oxon.) M.R.C.P., Physician to the Evelina Hospital for Sick Children, etc., etc. With sixty-seven illustrations. London: University Press, London and New York. (35 West 32nd Street.)

This work contains about four hundred pages and is intended to be a brief and concise summary of the pathologic, diagnostic and therapeutic features of diseases in children. The first few chapters are devoted to the development and nutrition of the child. Following these are sections devoted to diseases, the result of faulty nutrition. He then takes up the various infectious diseases and diseases of special organs. The statements of the author are concise and free from voluminous information that would be found in more extensive treatise.

**The Chemic Problem in Nutrition.** (Magnesium Infiltration). A sketch of the Causative Factors in Disorders of Nutrition as Related to Diseases of the Nervous System. By John Aulde, M.D. Cloth, 8vo, gilt top, pp. xvi, 410; 4 plate illustrations. Philadelphia, 1912. Price, \$3.00, postpaid.

The author of this volume is an adherent of the theory that most of the diseases to which the human body is heir, are the result of an excess of acid in the blood. Having established this theory to his own satisfaction, he next proceeds to show how this excessive acid can be overcome by magnesium infiltration. Personally we are inclined to think that the excessive acid is in the mind of the doctor rather than in the blood of his patients. Whether the magnesium infiltration exercises the beneficial effect chiefly in his mental faculties or not, we are not prepared to say. To those, however, who agree with this theory as to the causation of disease, the book will, no doubt, prove of interest.

**A Manual of Surgical Treatment.**—By Sir W. Watson Cheyne, Bart., C.B., D.Sc., LL.D., F.R.C.S., F.R.S., Hon. Surgeon in Ordinary to H. M. the King; Senior Surgeon to King's College Hospital, and F. F. Burghard, M.S. (Lond.), F.R.C.S., Surgeon to King's Hospital, and Senior Surgeon to The Children's Hospital, Paddington Green, London New (2d) edition. Thoroughly revised and largely rewritten. In five octavo volumes, containing about 3,000 pages, with about 900 engravings. Price, cloth, \$6.00, net, per volume. Lea & Febiger, Publishers, Philadelphia and New York, 1913.

The fourth volume of this very practical work takes up the surgical affections of the entire alimentary system. Beginning with the mouth, tongue and jaws, it covers fractures of the bones, tumors, congenital malformations, injuries, syphilis, tuberculosis and other diseases having a surgical bearing. With equal thoroughness it proceeds to the pharynx and esophagus, and then to the surgical affections of the stomach and intestines. This section includes methods of examination of the stomach, and general remarks on laparotomy and intestinal suture, and on affections of the abdominal wall. The treatment of the numerous pathological conditions to which the stomach and intestines are subject is gone into carefully and in detail. The last division of the book gives full attention to the rectum and anus. The illustrations, 208 in number, are unusually large and clear.

**The Modern Treatment of Nervous and Mental Diseases.**—By eminent American and British authors. Edited by William A. White, M.D., Superintendent of the Government Hospital for the Insane, Washington, D.C.; Professor of Nervous and Mental Diseases in the Georgetown University and in the George Washington University; Lecturer\* on Mental Diseases in the U. S. Army and U. S. Navy Medical School, Washington, D. C., and Smith Ely Jelliffe, A.M., M.D., Ph.D., Adjutant Professor of Diseases of the Mind and Nervous System in the Post-Graduate Medical School and Hospital; Visiting Neurologist to the City Hospital; Consulting Neurologist to the Manhattan State Hospital, New York, N. Y. Two octavo volumes, containing about 900 pages each, illustrated. Per volume, cloth \$6.00 net. Lea & Febiger, Publishers, Philadelphia and New York, 1913.

When one realizes that insanity and idiocy are increasing in some of the States faster than the population, and that a very large percentage of the feeble-minded men and women are not properly cared for and procreate mentally deficient children, the great importance and timeliness of a work dealing with the problems involved in this situation become at once apparent. While these volumes go fully into the most modern medical phases of the issues under discussion, they devote a large amount of space to the broader question of prophylaxis, which is obviously the department where the greatest and most far-reaching results can be attained. This work marks a new departure in giving full consideration to such subjects as Eugenics and Heredity in Nervous and Mental Diseases, Education, Sexual Problems, Educational Treatment of the Feeble-Minded, Delinquency and Crime, Immigration and the Mixture of Races, and Alcoholism and the Alcoholic Psychoses. It then takes up the treatment of the various forms of nervous and mental diseases, and discusses

them conjointly, for the authors and editors regard the nervous system "as inclusive of the mind." It exhibits throughout the most modern point of view, and the most advanced methods for handling these cases. It is of prime interest, not only to all medical men, but also to hygienists, government, State and municipal officials, legislators, military men, social welfare workers, charity organizations, and all those who have to do with the betterment of these unfortunate classes.

**Solidified Carbon Dioxide.** In the Successful treatment of Cutaneous Neoplasms and other Skin Diseases, with Special reference to Angioma, Epithelioma and Lupus Erythematosus. Fully illustrated—By Ralph Bernstein, M.D., Philadelphia, Pa., Clinical Instructor in Skin Diseases, Hahnemann Medical College, Philadelphia, Pa., Consulting Dermatologist to the Women's Southern Homœopathic Hospital, Philadelphia, Pa., etc., etc. Frank S. Betz Company, Hammond, Indiana.

The author of this monograph has probably had more practical experience with the treatment of cutaneous diseases by solidified carbon dioxide than any other specialist in the United States, and is therefore in a position to present the subject in a practical and authoritative manner.

In the volume now before us he has presented the subject briefly and concisely and has endeavored to give to the profession, in a practical way, the methods to be employed in using carbon dioxide in cutaneous manifestations and also the results of such treatment.

The work is divided into seven parts and in these the author takes up the origin of solidified carbon dioxide as a therapeutic measure, an explanation of its action on the skin, its advantages over other methods and the technique to be employed in the treatment of neoplasms and other cutaneous diseases. It is an eminently practical work and one well suited to the demands of the physician who desires the latest information on this subject.

**Progressive Medicine.** A Quarterly Digest of Advances, Discoveries and Improvements in the Medical and Surgical Sciences, Edited by Hobart Amory Hare, M.D., Professor of Therapeutics and Materia Medica in the Jefferson Medical College, Philadelphia, Assisted by Leighton F. Appleton, M.D., Instructor in Therapeutics, Jefferson Medical College, Philadelphia. Lea & Febiger, Philadelphia and New York, publishers. \$6.00 per annum.

This volume of *Progressive Medicine* opens with a very exhaustive and up-to-date summary of our knowledge of the diagnosis and surgical management of diseases of the pituitary gland.

For many years Dr. Fraser has devoted a great deal of his time to the study of this subject, and his summary of our present knowledge of this gland is very interesting and instructive reading.

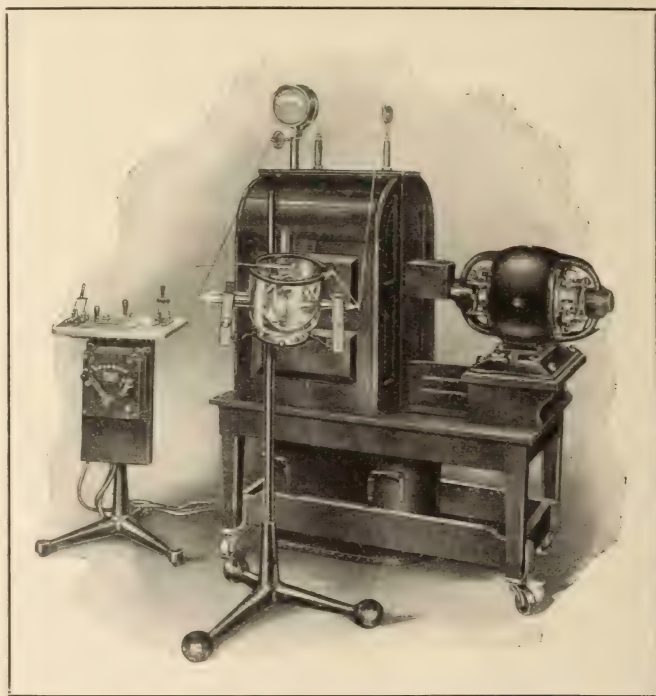
The article on "Goitre" is also a very practical one and his remarks upon the treatment of this disease by surgical and radiographic means are very practical and valuable.

Dr. Crandall's section, devoted to diseases of children, is a very timely one, and the physician who desires to prepare himself for a large number of children's disorders that occur during the summer, would do well to read this section carefully. The portion dealing with infant foods is especially valuable.



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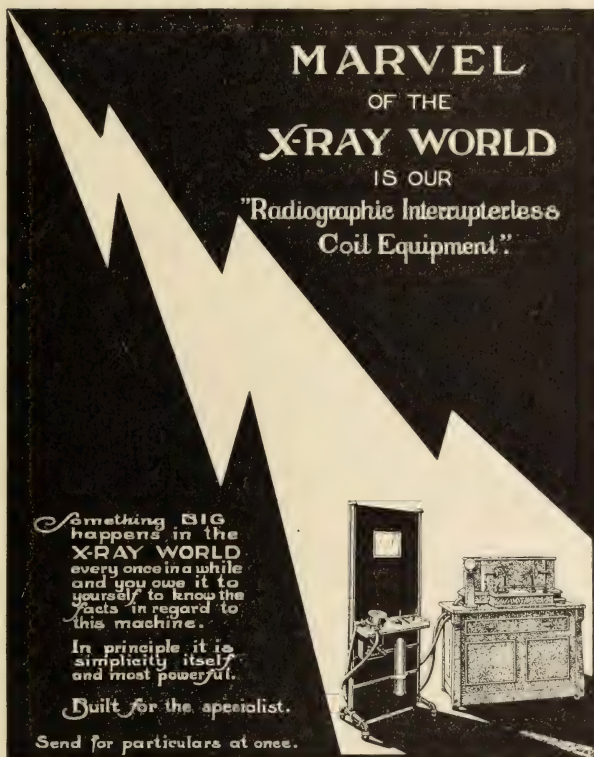
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CHICAGO

**Surgery of the Eye. A Hand-book for Students and Practitioners.**—By Ervin Török, M.D., Surgeon to the New York Ophthalmic and Aural Institute; Ophthalmic Surgeon to Beth Israel Hospital; Consulting Ophthalmologist to the Tarrytown Hospital, and Gerald H. Grout, M.D., Assistant Surgeon to the New York Ophthalmic and Aural Institute; Instructor in the Eye Department, Vanderbilt Clinic; Consulting Ophthalmologist to the Bellevue Hospital, First Division. Octavo, 507 pages, with 509 original illustrations, 101 in colors, and 2 colored plates. Cloth, \$4.50 net. Lea & Febiger, Publishers, Philadelphia and New York, 1913.

The Eye is one of the most important and delicate organs of the entire body, and the successful treatment of its diseases and injuries requires great skill and precision. As a large part of ophthalmic work is of a surgical nature, it is important that those interested in it should have in convenient form a practical statement of those operations which have yielded the best results. Such a book is of even greater value and importance to the general practitioner, who is almost certain at some time to be called upon unexpectedly to treat some injury of the eye because of its urgency.

This volume may claim two especially attractive features, its arrangement and its wealth of illustrations. The following plan has been pursued throughout the book: First, before describing each group of operations the authors have discussed the disease for the relief of which they are intended, and have given clear indications for the selection of the proper procedure in any given case. A detailed description of the steps of each operation then follows, with a list of all the instruments required. After this the complications that may occur at the time of operation and later are taken up, together with the post-operative care of the patient.

The authors have included all operations in common use to-day and also others that in their personal experience have given good results. This experience comprises fifteen years of practical work in Budapest, at the Royal Hungarian University Eye Clinic, with Prof. W. von Schulek, Prof. E. von Grosz and Prof. L. von Blaskovics; in Berlin with Prof. J. Hirschberg, and in New York at the New York Ophthalmic and Aural Institute, with Drs. Herman Knapp and Arnold Knapp.

The illustrations are all new and original, and over one hundred are in colors. They have been used unsparingly wherever it was possible to elucidate the text.

**Colorado Attractions for the Institute.**—The Transportation Committee does not wish to stale the members toward the Denver meeting, July 6th to 13th inclusive, but it is receiving so many inquiries in regard to vacation possibilities and attractions in the Rockies that it feels justified in setting before the Institute, through the journals, as best it may, some of the glories of the Rockies and some of the contemplations of the summer meeting in Denver.

Occasionally, a member who has been in the habit of summering abroad, or in the woods of Maine, the mountains of New Hampshire, or the Adirondacks, suggests he does not see how he can afford to come away out to Colorado for a few days and go back home to his usual summer vacation. To all such the committee feels that it may properly suggest the great desirability of this year making the visit to the Insti-



tute one for vacational purposes also. We of the interior and Great West always do this when we go to Institute meetings in the East. And now that the Institute is to meet at the foot of America's incomparable Rockies, whose glories have no equal in this or any other country, there is ample reason why all our members from the extreme East, New England and even the Middle West and South may well consider the thought of making the visit to Colorado a visit of the usual summer vacation period.

The committee is at work with the railroads of the State at this moment working up various excursions out into the heart of the Rockies. These are right at Denver's back door, in coming from the East, at her front door in coming from the West. Splendid snow-capped peaks and lofty mountain ranges are but fifteen miles from Denver, in plain view from our meeting place. The backbone of the continent is right at hand. The greatest mining camps of the world are but a half day distant. The splendid forest reserves that the government is wisely trying hard to conserve for future generations, that the history of Sidon and Tyre and the plains and forests of Lebanon may not be repeated, may be visited in less than a day. Colorado's splendid mountain fishing streams are along the line of each of the scenic railroads of the State. Splendid automobile roads course in every direction and ascend among the clouds at easy grades. Lakes at ten thousand feet, with motor boats and beautiful yachts are among the attractions for the summer, while at Glenwood Springs, Steamboat Springs, Ouray and many other attractive summer spots in the mountains there are comfortable hotels, fine bathing pools, indescribable mountain scenery, pack trains for mountain climbing, old-fashioned stage coaches for bye trips, cattle ranches many miles in area with thousands upon thousands of beeves making ready for the Easterners' tables under the chaps, quirt and spur of the festive cowboy.

In beautiful Estes Park, close to Denver, there are splendid camping sites with complete facilities, as also along Frying Pan, Roaring Fork and many other splendid trout fishing streams. The lodges along the Gunnison, as the Black Canon is approached, entertain hundreds of sportsmen every season, while back in Nature's fastnesses, away from the railroad, are innumerable virgin streams that splash and dash their silvery way toward the larger rivers, the delight of the Isaac Waltons of this State, and therefore a real delight to every lover of the rod who belongs to the Institute.

Nowhere under God's bright sun may the mineralogist of the profession find such possibilities as in Colorado. Leadville, reachable by the Denver & Rio Grande, one of the scenic railways of the world, and also by the Colorado Midland, which goes right up over the crest of the country, is one of the largest silver and gold camps of the world. Cripple Creek and Victor have never been more entertaining than right now. The Short Line from Colorado Springs is a line of scenic bewilderment. It takes but a day up to Cripple Creek and return to Colorado Springs, three hours by rail each way, at an expense of but \$3.00. No one who can take it should miss this particular side trip. On the Rio Grande the new camp of Eagle is springing up like a mushroom in the night, because of the splendid discoveries of virgin silver, lead and copper that have been made within the last few days. A fine ride from Eagle County is the stage jaunt of fifteen miles over the mountains, at an elevation of about ten thousand feet, from Wolcott to State Bridge, on the Moffatt Line, thence by rail to Steamboat Springs.

One of the famed and justly famous jaunts in Southwestern Colorado is down to Ouray by rail, over Marshall Pass, nearly 11,000 feet above the sea, through the incomparable Black Canon of the Gunnison, across the Great Divide, down to the developing Uncompaghe Valley at Montrose, where the road branches off to Ouray. A night at this Switzerland spot in America, there is none other like it, prepares for the twenty-mile stage ride over the old Mears Toll Road, through the long-abandoned mining camps of Ironton and Red Mountain, now taking on new life, to the pretty little city of Silverton, where the Denver and Rio Grande Southern is boarded for Durango through Las Animas Canon and other indescribably picturesque spots in the Southwest. If interested in Radium, Vanadium, Uranium and other ores of allied classes these are to be viewed in the mining in Paradox Valley, near Telluride.

In short, if this may be called an abbreviated announcement, Colorado offers the Institute member such a variety of educational and entertaining attractions that no member who can attend the Denver meeting should go home without a month in the Heart of the Rockies.

Restful, invigorating, enjoyable, intoxicating, the miles-high atmosphere makes the red blood course repairingly through every tissue, the worries of life are forgotten, the eye and brain are rested, and the visitor goes home refreshed and made new for the work before him. Come to Colorado not alone to help us homœopathically—and we need that help—but to make this summer the enjoyable vacation of your life. God made these mountains for Man. Let Man come and enjoy His magnificent handiwork.

C. E. Fisher, Chairman.

**Homœopathic Medical Society of the County of New York** held its regular monthly meeting at the New York Academy of Medicine, on Thursday evening, at 8 o'clock.

Dr. G. Harlan Wells, of Philadelphia, read a paper entitled: "A Consideration of the Diagnosis of Cryptogenic Fevers"; Dr. W. N. Berkeley presented a paper entitled: "What Progress Have We Made in the Clinical Use of Internal Secretions?" Dr. Lindsley F. Cocheu reported the results of "Original Investigations In Regard to the Blood Findings in the Third Stage of Tuberculosis with Special Reference to the Eosinophile Count."

The meeting was well attended and all papers were generally discussed.

**The Homœopathic Medical Society of New Castle, Delaware**, held its regular monthly meeting, April 11th, 1913, at Wilmington, Delaware.

The paper of the evening was read by Dr. E. T. Negendank on: "The Significance of Irregular Pulse."

**The Atlantic City Homœopathic Medical Club** held its Fifth Annual Open Meeting, at Galen Hall, Friday evening, April 18, 1913.

The following papers were read: "Intravenous Anesthesia," with a report of 150 cases—Dr. J. W. Hassler; "An Effort to Re-Establish Old Friendships. The Differentiation of the Remedies Applicable for the Relief of Heart Symptoms, Whether Reflex or Organic in their Origin"—J. B. Gregg Custis, Washington, D. C.

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The 464th Regular Meeting of the Homœopathic Medical Society, of the County of Kings, was held at the Medical Library Building, Brooklyn, March 11, 1913. Dr. William Henry Abbott, Hahnemann Medical College, Philadelphia, '11, was proposed for membership. The bill recently introduced into the New York State Legislature, increasing the powers of the Board of Regents in the control of the practice of medicine was discussed and referred to the Legislative Committee with power to take action in opposition. The following papers were read: Dr. H. D. Schenck, "Phosphorus in Retinitis"; Dr. James W. Fox, "Nuxvomica in Chronic Malaria," and "Mercurius Corrosivus in Cystitis"; Dr. George H. Ding, "Bryonia in Rheumatism," and "Argentum Nitricum in Neuroses of the Stomach"; Dr. N. L. Damon, "Two Cases of Myocarditis"; Dr. George S. Ogden, "Paris Quadrifolia in Eye Condition," and "Hepar Sulph. in Ptyalism." Dr. John B. Garrison spoke on the propagandism of the American Institute of Homœopathy, as follows:

Mr. President and Members: You all know that the Institute has decided to take up the work of homœopathic propagandism, and it occurs to me that possibly you may want to know why and how such action may be necessary, and how we intend to use the funds that are being raised for this purpose. If homœopathic physicians had continued to be as steadfast in their work for and in homœopathy as were the old time members and if in their work they would continue to instruct their patients along the fundamental lines of homœopathy it would not probably be found necessary for the committee to take such steps as they have taken. As the homœopathic profession grew and became more prominent they have left out that work and it has been found that they are not telling their patients and outsiders just what homœopathy is. They have been content to be merely physicians. In one way it was right but in another way it is not proving to be the best way. There is a feeling among the laity that the schools of homœopathy and allopathy are coming close together and it is hardly worth while to distinguish between the two. It has become a difficult task for a stranger coming into town to find a homœopathic physician. The drug stores will not aid him; at least they will not in Manhattan. I do not know if it is any better in Brooklyn. In olden times the homœopathic physicians used the name and people knew them, as they know the osteopaths now, by their signs. In our day a homœopathic physician cannot be found so readily. That is why we find it necessary to work along the lines announcing to the public that homœopathy still exists and is still doing its work; that homœopathic physicians are doing the same kind of work as formerly. This Society is undoubtedly composed of physicians who are proud of their profession. You can do much toward the propaganda. Patients ask me what is the difference between the schools. They do not know, and they think it is the small dose of medicine. They do not know how you are healing them, unless it is by your personality. We believe that the propaganda is necessary; to go among the laity and to instruct them, and to tell them some of the fundamental truths as to the difference between homœopathy and allopathy. Now, to do this, in one word, requires "publicity." The idea of the trustees of the Institute is to use these funds for public lectures in different towns and cities, to provide halls, and speakers; men who believe in homœopathy and who will instruct the laity as to what it is and what is its history. To tell the public what it will be interested in, in every town and city. Where homœopathy becomes better known, it will increase the

demand and increase the number of students. There will be a press agent who will keep the papers in the news of the colleges and institutions; the improvements and other matters relating to the colleges that will show that they are thoroughly up-to-date. Their sons will want to attend lectures in the homœopathic colleges. Publicity is the one word we are having in our minds, for homœopathy must be made popular. There is no use going among physicians. We want to go outside and to tell the people that homœopathy is just the same to-day as when it was first introduced by Hahnemann. I think every one here has received the red card from the Institute with the circular, and I hope you will sign the card and send it in.

Dr. George F. Laidlaw, of Manhattan, was to have read a paper on "Diagnostic Problems," but a mistake in dates made it impossible for him to be present and the Society has that paper to look forward to for a future meeting.

L. D. Broughton, Secy.

**Practice for Sale.**—Philadelphia physician, thirty years in one place, will give practice and introduce successor who buys property and equipment. This includes office furniture, two coils, two therapeutic lamps, vibrators, high frequency, and other electrical apparatus, auto and brick garage. Cash income has been over \$8,000. Right man can do better. Address: A. E. H. care of "Hahnemann Monthly."

**Practice For Sale.**—An established practice, located in a growing neighborhood in West Philadelphia, situated near corner of a main street, will be given away free for price of residence and office fixtures, including X-Ray and High Frequency apparatus, etc. Reason for selling—going to specialize. Address: F. H. A., care of "Hahnemannian Monthly."

**Graduation Exercises at Hahnemann Medical College and Hospital.**—The sixty-fifth annual commencement exercises of the Hahnemann College and Hospital will be held on **Thursday, June fifth, at twelve o'clock noon**, at the Garrick Theater. An organ recital will be given at eleven-thirty. The graduation address will be delivered by Ellis Ames Ballard, Esq., and short addresses by the Dean and the President of the College.

The annual meeting of the Alumni Association will be held at the college directly after the commencement exercises and there, Dr. Horace B. Ware, president of the Alumni Association, will deliver his address, and Dr. Wm. B. VanLennep, Dean of the college, will present his report of the work done the past year by the college. After the Alumni meeting the college and hospital will be open for inspection and details of teaching and the care of the patients in the hospital will be explained.

The Alumni banquet will be held in the evening in the roof garden of the Bellevue-Stratford. Dr. H. L. Northrop will act as toastmaster, the speakers of the evening being Judge Howard Davis, Wm. T. Tilden, President of the Union League; John Gribble, Esq., who will represent the trustees, and Dr. H. H. Snyder, who will represent the graduating class.

A cordial invitation is extended to the alumni to be present at all these functions.

**Institute Notes.**—The regular monthly meeting of the Hahnemannian Institute was held in the college building, Wednesday evening, April 9th, at 8 o'clock and was largely attended.

The feature of the evening was an illustrated lecture, by Dr. C. W. Perkins, of Princeton, N. J., on "Fractures and Dislocations" (with special reference to those found among athletes). After reading several interesting articles on the subject, written by himself, which clearly set forth the important facts to be remembered in the treatment and handling of such cases, the speaker gave a most interesting and instructive lecture on the subject, which was thoroughly enjoyed by all present as was manifested not only by the attention given, but by a rising vote of thanks.

After hearing the reports of the various committees, most interesting of which was the report of the Dance Committee, who reported not only that the affair was a complete success socially, but financially as well. The remainder of the meeting was given over to the election of officers for the ensuing year. The result of the election being as follows: President, A. A. Perkins; vice-president, C. I. Pratt; secretary, E. T. Jones; treasurer, E. M. Blew.

At the close of the election the new officers were installed and after a short speech from each, the meeting adjourned.

**Denver in July, the Place for You.**—The local committee of arrangements meets and dines regularly every Thursday evening at the Albany Hotel, where the Institute is to hold its sessions in July. Each meeting is more largely attended and more interesting than the preceding.

If the happy, enthusiastic and concerted action of the members of this committee is any indication of what may be anticipated by those who come to the Institute the meeting will be a hummer; well worth the sacrifice in time and money necessary to attend.

The scientific sessions will be taken care of by those elected by the membership for that purpose; in this there promises to be no cause for misgivings.

The local committee is bending its energies toward giving you the kind of entertainment which will make you doubly thankful that you came; thankful that you live, and thankful you can see Denver and Colorado under such favorable circumstances; towards showing you scenery that can be excelled no where in the world; forms of entertainment which are distinctive and typical of Colorado on its gala occasions, and other things which you have never seen elsewhere and may never see again.

In how far the committee may succeed in its efforts remains to be seen by those who are fortunate enough to attend the A. I. H. in July. We, who have heard the plans, which we are not at liberty to tell, because some of the stunts are intended to surprise the seniors, et al, believe no one will be disappointed except the fellow who stays away. Whether you are in the habit of attending the sessions of the Institute or not, come to Denver; whether a member of the Institute or not—come. If a regular attendant, keep it up,—pass it along. If "a stay at home" break away. Come to Denver that you may have something pleasant to think and talk about in your later years; something to tell your children and grandchildren.

As for your wives and sweethearts, why, of course, you are expected to bring them with you. The ladies have plans for them which are sure to please.

Publicity Committee.



# THE HAHNEMANNIAN MONTHLY NEWS AND ADVERTISER

A Medical Newspaper

JUNE, 1913

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**The Surgical Clinics of John B. Murphy, M.D.,** at Mercy Hospital, Chicago. Volume II. Number II. (April, 1913). Octavo of 171 pages, illustrated. Philadelphia and London: W. B. Saunders Company, 1913. Published Bi-Monthly. Price per year: paper, \$8.00; cloth, \$12.00.

This volume of Murphy's Clinics contains several interesting articles bearing on the subject of gastric surgery. Various phases of gastric and duodenal ulcer are discussed, both as regards their diagnostic and surgical aspects. The volume closes with a brief and practical description of the method of continuous proctoclysis advocated by Dr. Murphy.

**A Reference Hand-book of the Medical Sciences** Embracing the Entire Range of Scientific and Practical Medicine and Allied Science.—By various writers, first and second editions edited by Albert H. Buck, M.D. Third Edition completely revised and rewritten, edited by Thomas Lathrop Stedman, A.M., M.D. Complete in eight volumes. Volume I, illustrated by numerous chromolithographs and six hundred and eleven fine half-tone and wood engravings. New York, Wm. Wood & Co.

It is rather remarkable that a work in eight volumes should be now passing through its third edition. Such, however, has been the demand on the part of the profession for a work containing general information on all subjects relating to medicine that the publishers are now called upon to issue a third edition of this classical work.

A detailed description of the subject matter of this volume is scarcely necessary to the members of the medical profession, most of whom have had occasion to consult a reference hand-book at some time or other. It is sufficient to say that in compiling it the publishers have sought the assistance of more than five hundred of the ablest physicians

and most expert specialists in the country. Each of these men has written a complete but concise statement of our present knowledge of the various subjects assigned to him.

The subject matter is arranged as in most encyclopedias, in alphabetical order and there is also a system of cross references which enables the reader to obtain all available information on this subject. In these days when the public demands that the physician shall have at least a superficial knowledge of everything relating to medicine or to any of its branches, it is necessary that every progressive physician should have in his library a work of this character for ready reference when the occasion demands.

As a reference hand-book, it is undoubtedly the most complete and authoritative work of such character published in America to-day.

**Meeting of Kings County Medical Society.**—The 466th regular meeting of the Homœopathic Medical Society of the County of Kings was held at the Medical Library Building, Brooklyn, May 13, 1913. Dr. Roy Upham, president in the chair.

Dr. Cornelia C. Brant, of Brooklyn, spoke on the advisability of forming another hospital in Brooklyn. A paid worker had canvassed the hospitals of the two cities and visited physicians to ascertain the feeling regarding the plan and it seemed to be commended by all. The need was for a hospital where women could send patients and retain control over their treatment and this applied to women of the allopathic as well as the homœopathic schools of medicine, and to many men who were not connected with the hospitals.

Dr. George F. Laidlaw said that there is a need in New York for an institution where women can have access to treat patients. Women now hold subordinate positions in hospital work and they need opportunity to develop under responsibility and if they had a hospital it would be of value to them, it is one of the elements in higher education. The hospital worker is the better physician and every physician should try to obtain that means of education.

Dr. John F. Ranker, of Brooklyn, spoke in favor of the plan and moved that the Homœopathic Medical Society of the County of Kings endorse the plan and pledge itself to render it moral and financial support. The motion was carried.

The Homœopathic Medical Society of the County of New York, furnished the papers for the evening and Dr. John Hudson Storer, president, was invited by Dr. Upham to preside.

The program included: "Some Experiences with Blood Pressure," by Dr. Egbert Guernsey Rankin. "Historical Charts. The Origin and Growth of Modern Therapeutics," by Dr. George F. Laidlaw. "Later Experiences Regarding Intra-venous Anaesthesia," by Dr. Charles Francis Honan. "Report of Cases Citing Unusual Results following Tonsil Removal," by Dr. Harold A. Foster.

About forty members of the New York Society made the trip to Brooklyn and with a large gathering of the Kings County Society, made a very interesting evening, the discussion being active and instructive. The papers were discussed by Dr. W. L. Love, Dr. A. J. Stewart, Dr. Harold A. Sanders, Dr. J. W. Dowling, Dr. Francis T. Brennan, Dr. W. H. Freeman, Dr. T. Drysdale Buchanan, Dr. W. B. Winchell, Dr. Egbert Guernsey Rankin, Dr. Storer, and others.

The Kings County Society will furnish the papers for the next meet-

ing of the New York Society, which will be held at the Academy of Medicine, June 12th, the second Thursday, at 8.30. The hope was expressed that these interchanges of meetings would be an annual fixture, Dr. Storer remarking that the meetings would be of great benefit not only to the members and the societies but to homœopathy in general. There is power in numbers, and as the cordial relations are increased there will be just so much more power to aid each other in the stand for homœopathy. He extended a cordial invitation to physicians to visit the Academy of Medicine on June 12th.

L. D. Broughton, Secy.

**Personals.**—Dr. Edgar Bieber has opened an office at 917 Jefferson Street, Buffalo, N. Y.

Dr. Benjamin K. Fletcher announces the removal of his offices to 319 South 16th Street, Philadelphia. Hours: 8 to 10 A. M.; 5 to 7.30 P. M. Sunday, 9 to 11 A. M. only.

Dr. John G. Wurtz announces the opening of a Clinical Laboratory, at 2103 North Howard Street, Philadelphia. Urinalysis, Blood Counts, Widsals, Gastric Analysis, Bacteriological, and other Laboratory Tests. Drawings and Charts. Specimens received at 2103 N. Howard Street or 1621 Arch Street.

Dr. Jos. H. Fobes, of New York, desires to announce that after July 1st, he will be at the "Breakers," Spring Lake, N. J. On Wednesdays from 11 to 1, Dr. Fobes will be at his New York office, No. 1 West 68th Street, New York City. Surgery and Gynecology.

Doctors Edward R. Gregg, George B. Moreland, Frederic S. Morris and Edward H. Pond announce that they have associated themselves for the exclusive practice of Surgery, Gynecology, Proctology, Roentgenology, Dermatology, and have opened offices in Suite 303, Second National Bank Building, Ninth Street and Liberty Avenue, Pittsburgh. Hours: Doctors Gregg, Moreland and Morris, 12 to 2; Doctor Pond, 10 to 1. Special hours by appointment.

Dr. A. B. Norton, 30 East Fifty-fifth Street, New York, southeast corner of Madison Avenue, will leave on June 19th for a trip to Australia, New Zealand and the South Sea Islands, and will return on October 5th.

Dr. Norton's associate, Dr. Calvin E. Williams, will be in the office during his absence.

**Thirty years' established practice in Philadelphia for sale;** including large library, two electric coils, two high frequency coils, and many other electrical, surgical and gynecological instruments, desks, filing cabinets, Zentmayer Centennial microscope, and accessories, large automobile.

Will rent house and garage for a term of years, and remain with successor for two or three months. Address: A. E. H., care of "Hahne-mannian Monthly."

**Married.**—Mr. and Mrs. William Henry Warrin announce the marriage of their daughter, Gertrude Kimber, to Dr. Howard Leslie Fry, on Wednesday, the fourth of June, nineteen hundred and thirteen, at seven o'clock, Epiphany Chapel, Seventeenth and Summer Streets, Philadelphia. Dr. and Mrs. Fry will reside at 3509 Baring Street, Philadelphia.



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 IS OUR  
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Send for particulars at once.

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**Mixed Bromides Desirable.**—The reliability, as a sedative, of Peacock's Bromides, is based upon the fact that only pure salts are employed in this compound, and each of its five bromides enhances the action of the others. The most frequently used bromide has long been the potassium salt; although it is well known to be somewhat depressing to the heart and injurious to the stomach in cases where its use is deemed necessary for a considerable length of time. This may be almost entirely avoided by administering it as combined in Peacock's Bromides, a preparation which assures the highest possible degree of therapeutic action with the least possible tendency toward "bromism"; hence the doctor may feel confident in prescribing Peacock's Bromides that he is ordering only the purest salts and getting fifteen grains to the dram, of the desirable combination of Ammonium, Calcium, Lithium, Potassium and Sodium Bromides—in a most delightful elixir. This vehicle effectively covers the natural acridness of the bromides and proves highly satisfactory to the patient. By ordering the original, eight-ounce bottle, from his druggist, the careful physician will ensure his patient getting the five salts in purest, pleasantest form.

**The International Homœopathic Council** will meet at Ghent in August, 1913. This Council is the outcome of a suggestion offered at the International Congress in London, 1911, and was organized for the purpose of drawing closer together the Homœopathic Institutions of all nations.

Dr. James H. McClelland, of Pittsburgh, is president of the Council; Dr. George Burford is vice-president; Dr. C. Petrie Hoyle, of London, is treasurer and associate secretary.

A number of important subjects will come up for consideration this year and among which may be mentioned the following:

(a) To assist our Swedish colleagues to make a stand against a violent anti-homœopathic campaign conducted with little scrupulousness in the press and in society by the orthodox physicians. Dr. Hoyle went by invitation as a representative of the Council and delivered lectures in the main centres of Sweden to large and distinguished audiences. In these he demonstrated by lantern slides and speech that Homœopathy has a world-wide significance, and, though the cause of a minority, is yet a cause so strong as to obtain great support and official recognition. The effect of his lectures was very marked.

(b) In response to an appeal from Russia, where a bill, specifically to close every Homœopathic Pharmacy in Russia, of which there are a number of very fine ones, is now before the Duma (in Committee), which, if passed, will prevent homœopathic doctors from prescribing their medicines and chemists from keeping or dispensing them. A vast mass of legal information relating to the Pharmacy Acts and position of homœopaths thereunder in the States of America, England, France, Germany, Austria, and other countries was collected by the Executive and forwarded to St. Petersburg. Our Russian colleagues hope by means of this accumulated weight of evidence to obtain legal protection for themselves and freedom of pharmacy.

(c) By invitation from German colleagues, Dr. Hoyle undertook a short tour in Germany, delivering the lectures which proved so successful in Sweden. He visited Magdeburg, Berlin, Darmstadt, Frankfurt, and Stuttgart, and in every place great enthusiasm was aroused. (It was found necessary to repeat the address in Stuttgart.) Visits are proposed

in the autumn to St. Petersburg and Dresden, and a "Private Invitation" Drawing Room address of some importance in Berlin. All the work hitherto done has been financed out of the freewill offerings of individuals and societies. The executive has paid its way and has a balance in hand.

**Common Sense in Infant Feeding.**—It is a welcome relief to note how medical opinion is changing on the question of infant feeding, and how complicated formulæ are gradually giving place to the dictates of common sense.

Percentage feeding and caloric values are undoubtedly of value, only as an indication; the average infant has as many idiosyncrasies as an adult, and the old saying: "One man's meat is another man's poison," comes home with tragic truth when applied to infant feeding.

Fresh cow's milk, psychologically modified, (not mechanically or chemically modified), to suit the individual case, is the best and sanest method of caring for the artificially fed child.

The one food that offers possibilities of doing this is Benger's Food, containing natural digestive ferments, it enables the mixed food and fresh milk to be presented in a simple form, promoting healthy, steady growth, and at the same time maintaining the even balance of nutrition.

Feed the child, hitherto pale, emaciated, fretful and colicky, on Benger's, and note the results; the tiny limbs round out, intestinal fermentation disappears, and irritation gives way to contentment.

A doctor recently wrote us: "My interest is vital, for your food has practically snatched my infant from a death bed."

These facts admit of no doubt or argument. Benger's Food is one of the greatest contributions to food science.

The Benger's Food Company, New York, will be glad to send formulæ, samples, etc. Mention this paper when writing.

**Why Anusol Suppositories Maintain Their Absolute Supremacy Amongst Rectal Remedies.**—Anusol Suppositories have for nearly a decade and a half maintained their world-wide reputation among the medical profession as the most effective, the safest, for the patient (in the end) the most economical and for the physician the most credit-bringing of all topical rectal remedies.

**The most effective**, because they unite in unequalled completeness all the prerequisites of correct and successful rectal medication, affording simultaneously the maximum anodyne, stool-softening (strain-relieving), antiseptic, astringent (decongestive) desiccant, granulating, healing and tonic action.

**The safest**, because they are absolutely free from narcotic, caustic or other toxic ingredients, therefore, may unhesitatingly be used in both sexes, from infancy to old age and in the presence of every possible local or systemic complication.

**The most economical**, because their deservedly somewhat higher price is negligible in view of the fact that they achieve the most thorough and lasting results in the reasonably shortest space of time.

**The most credit-bringing**, because they seldom fail to meet the exigencies of cases which have resisted all other forms of medication and very frequently entirely obviate surgical intervention where, before their employment, it positively seemed to be the last resort.



## PENNSYLVANIA STATE NOTES.

**Entire Membership of Class Receives Diplomas at 65th Commencement of Hahnemann Medical College.**—Thirty-one members of the graduating class of Hahnemann Medical College and Hospital, became accredited physicians on Thursday, June 5th, when degrees in medicine and homœopathic medicine were conferred at the conclusion of the sixty-fifth annual commencement exercises in the Garrick Theatre at noon.

The Hahnemann graduates were the first of nearly 400 young men and women who were sent out from the six medical colleges of this city. Graduates of the various local medical institutions are leaders among the physicians and surgeons everywhere, and the Hahnemann College is well represented by its prominent alumni. The present class includes many from distant parts of the country, who will return to their homes to practice. Others will go abroad for further specialization and experience.

Elaborate commencement exercises marked this sixty-fifth graduation ceremony, the faculty, the trustees, as well as the graduates themselves occupying the platform in academic garb. The musical program was an impressive feature of the occasion.

Ellis Ames Ballard was the orator of the occasion. The degrees were presented by Mr. Charles D. Burney, president of the Board of Trustees.

In the afternoon the annual meeting of the Alumni Association and the election of officers was held. The various departments of the hospital and college were open for inspection, and the commencement guests visited the buildings. The Alumni reunion dinner was held in the evening at the Bellevue-Stratford.

The list of graduates who received diplomas is as follows: Joel Thompson Boone, Pottsville, Pa.; G. Walter H. Conrad, Philadelphia, Pa.; Asa Fenton Copeland, Philadelphia, Pa.; Joseph Raymond Criswell, Philadelphia, Pa.; Elwood Emerson Downs, Franklinville, N. J.; George Alexander Enion, Chester, Pa.; Antonio Esposito, Hammonton, N. J.; Russell Morrison Evans, Ebensburg, Pa.; William J. Felsburg, Jr., Minersville, Pa.; Robert Pemberton Gerhart, Philadelphia, Pa.; Ralph Dunleavy Killen, A.B., Philadelphia, Pa.; E. Paul Kitchin, Philadelphia, Pa.; Ray Calvin Klopp, Reading, Pa.; George William Krick, Jr., Hazleton, Pa.; Robert Leroy Leighton, Manasquan, N. J.; Philip John Lewert, Scranton, Pa.; Harry Harrison Lewis, A.B., Ashland, Pa.; John Edward Loftus, 2d, Oak Lane, Pa.; John Philip Mayer, Philadelphia, Pa.; J. Paul McComb, Youngstown, Ohio; John Harvey McCutcheon, Philadelphia, Pa.; Robert H. Murdoch, Jr., Wilkes-Barre, Pa.; Charles Benjamin Reitz, Walnutport, Pa.; Walter Arthur Schmitz, Philadelphia, Pa.; Homer Hess Snyder, Berwick, Pa.; Cyrus Walter Truxal, Ph.B., Meyersdale, Pa.; Everett Allen Tyler, Ph.B., Camden, N. J.; Charles Francis Voorhis, Palmyra, N. J.; Henry Pratt Webb, Portsmouth, Va.; Graham Ormond Wellman, New York City, N. Y.; Chester Walton Young, Hollidaysburg, Pa.

The following prizes were awarded: For general scholarship (Senior Year). First Prize, \$75.00, Charles B. Reitz, Walnutport, Pa. Second Prize, \$50.00, Everett A. Tyler, Camden, N. J. Third Prize, \$25.00, Philip J. Lewert, Scranton, Pa.

Prize in Pathology, \$25.00, offered by the Professor of Pathology to

a member of the second year class. Awarded to Harold P. Peckham, Waterford, N. Y. Honorable mention, Max Riebenack Stockton, Swarthmore, Pa., and Alfred Desch Strickler, Lebanon, Pa.

Prize in Chemistry, Urinalysis Set, offered by the Professor of Chemistry to a member of the first year class attaining the highest average in this branch. Awarded to Hugh J. Porter, Appleby, Ont., Can. Honorable mention, Reuben Peterson, Swissvale, Pa.

Prizes in Toxicology, Analysis Sets, offered by the Professor of Toxicology to the members of the second year class attaining the highest averages in this branch. Awarded to William Lemmon Martin, Philadelphia, Pa., and Harry Malcolm Read, York, Pa. Honorable mention, Harry Dellmarr Conley, Philadelphia, Pa.

Prizes in Pharmacy, United States Pharmacopoeia, offered by the Professor of Pharmacy to the members of the first year class attaining the highest averages in this branch. Awarded to Work A. Streeter, Waco, Texas, and Reuben Peterson, Swissvale, Pa. Honorable mention, C. Seaver Smith, New Haven, Conn.; Thomas H. Snyder, Philadelphia, Pa., and Donald Renwick Ferguson, Philadelphia, Pa.

Prize in Histology, \$25.00, offered by the Professor of Histology to the member of the first year class attaining the highest average in this branch. Awarded to Donald Renwick Ferguson, Philadelphia, Pa. Honorable mention, Charles Walker Lane, Philadelphia, Pa.

**Five Scholarships Promised by Unknown Donors.**—One thousand dollars was contributed on Monday, May 5th, to the general endowment fund of the Hahnemann College and Hospital by a woman whose name was not made public. Five scholarships were also promised by three donors to be announced later. The value of each scholarship was said to be \$5,000.

The gift of a Draeger pulmotor to the hospital by Walter E. Hering, for resuscitation of asphyxiated patients, was acknowledged with thanks by the meeting. Similar action was taken concerning an automobile ambulance donated by Mrs. George C. Thomas. Trustees whose terms had expired were re-elected, and Walter E. Hering was named as the successor of the late George Burnham, for many years a member of the board.

The following trustees were re-elected: Charles P. Perkins, William C. Foulke, Harry S. Hopp, Doctor Augustus Korndoerfer and Doctor Wm. B. Van Lennep. To fill the vacancy caused by the death of George Burnham, Sr., Walter E. Hering was chosen as a member of the Board of Trustees. The reports of the different committees showed that, excepting the great need of money, the institution made considerable progress during the last year. Within the last three months contributions amounting to \$21,000, including scholarships were received. There were no changes made in the medical or executive staffs excepting the new internes picked for the hospital upon their graduation this June.

**Homœopathic Hospital of Reading, \$6,436 Short.**—The captains of the Homœopathic Hospital \$50,000 campaign announced at the meeting on Tuesday evening, May 13th, that a total of \$43,563.66 had been subscribed, including \$2,850 provisionally, leaving a balance of \$6,436.34 to be collected. The campaign will be continued.

The captains made these reports: S. S. Schweriner and J. W. Essig,

\$1,257.25; H. J. Dumn, \$300.00; M. L. Wilkinson, \$155.00; W. W. Bausher, \$223.25 and 1,000 loaves of bread; C. Mill, \$150.00; W. W. Light, \$125.00; Lady Managers, \$100.00; Executive Committee, \$831.99, of which \$500.00 was by the American Iron and Steel Company.

Employees of O'Reilly & Blatt Foundry, \$31.00; employees of Carpenter Steel Works, \$142.00; employees of Textile Machine Works, \$138.25; Professor Warren F. Teel presided at the meeting.

The secretary of the campaign was discharged Tuesday evening, and left for Pittsburgh, where she will conduct a campaign.

**Smaller Hospital Grants Reported.**—The greatest dissatisfaction is expressed by friends of big charitable and semi-charitable institutions over the cuts already made and proposed by the House Committee on Appropriations. This committee, under the control of the administration, is making the usual large appropriations to the small institutions, while some large ones will receive much less than two years ago.

The House Committee reduced the request of the Medico-Chirurgical Hospital, in Philadelphia, from \$290,000 to \$180,000, while Hahnemann received \$140,000, the exact amount requested.

The committee, acting under instructions of the Governor, will not report out the appropriations for the University of Pennsylvania, State College and the University of Pittsburgh until the Senate has acted upon the utility commission and the workmen's compensation bills.

In the bills reported on Wednesday, May 21st, the appropriations for Philadelphia institutions, as compared with what they received two years ago were:

	Reported	Given two years ago
Women's Homœopathic .....	\$40,000	\$30,000
St. Joseph's .....	80,000	60,000
St. Mary's .....	50,000	40,000
Medico-Chi .....	180,000	250,000
West Philadelphia General Hom- œopathic .....	21,000	16,000
Rush .....	60,000	50,000
Women's .....	70,000	45,000
Mercy Hospital .....	12,000	
Mount Sinai .....	85,000	48,000
Wills Eye .....	35,000	25,000
Northeastern .....	2,000	
Stetson .....	5,000	
Howard .....	20,000	14,000
Hahnemann .....	140,000	120,000

**New Hospital Staff Named.**—The Board of Managers of the Chester County Homœopathic Hospital, held a meeting on Tuesday evening, May 13th, at the home of Miss Sarah Bailey, on North Church Street, at which several committees were appointed, and other matters concerning the new hospital considered.

Members of the board present were: George W. Conway, president; George K. McFarland, treasurer; Horace F. Temple, secretary pro-tem; Miss Frances E. Zook, of Downingtown; Miss Sarah Bailey, W. K. Biles,



of Downingtown; Edward F. Bracken, of Paoli; J. F. Taylor, C. P. Faucett and Doctor S. A. Mullin, chief of the staff.

The medical and surgical staff for the coming year was appointed by Doctor S. A. Mullin, as follows: Doctor Morris Hughes, Doctor A. W. Gregg, of Kennett Square; Doctor C. E. Winsmore, Downingtown; Doctor W. L. Hamilton, Malvern; Doctor M. W. Mercer, Downingtown; Doctor J. O. Hicks, Doctor C. R. Palmer, Doctor S. L. Barber and Doctor Levi Hoopes.

Consulting physicians: Doctor H. L. Northrop, Doctor Warren C. Mercer, Doctor G. Harlan Wells, Doctor W. R. Hammond, Doctor Wm. M. Speakman, Doctor O. G. Haines, Doctor Fred W. Smith, Doctor Chas. M. Thomas, Doctor Augustus Korndorfer, Doctor Ralph Bernstein, Doctor John T. Tuller, Doctor L. T. Ashcraft, all of Philadelphia.

Superintendent of Nurses, Miss Mary C. Davies. The president, George W. Conway, appointed the following committee on Nurses' Training School: From the Board of Managers, Miss Sarah Bailey, Horace F. Temple, Edward F. Bracken; from the Medical Staff, Doctors Hamilton, Hughes and Palmer. Representing the County Auxiliary, Mrs. G. K. McFarland.

**The Homœopathic Medical Society of the County of Philadelphia**, held its regular monthly meeting on Thursday evening, May 8th, 1913, at 8.30 o'clock, in the Elkin's Memorial Clinical Amphitheatre. The scientific program consisted of the following: "Spinal Anaesthesia," practical demonstrations, W. Wayne Babcock, M.D.; "Practical Illustrations of the Ionic, or Electrochemical Treatment of Cancer," G. Betton Massey, M.D. The nomination of officers for the ensuing year took place at this meeting which was well attended.

Wm. M. Sylvis, M.D., Secy.

**The Germantown Homœopathic Medical Society**, held its regular monthly meeting at the "Majestic," Broad and Girard Avenue, on Monday the nineteenth of May, 1913, at nine o'clock in the evening. Doctor Wm. M. Hunsicker read a paper on "Two years' experience with Salversan in the treatment of two hundred and fifty cases," which was very ably presented, and proved to be an interesting feature of the occasion.

Landreth W. Thompson, M.D., Secy.

**The Clinico Pathologic Society of Philadelphia**, held its regular monthly meeting at Hahnemann College, on Saturday evening, May 17th, 1913, at 8.30 o'clock. Some interesting papers read were as follows: "Plastic Bronchitis," J. G. Wurtz, M.D.; "Pneumonia and its Complications in Childhood," C. S. Raue, M.D.; "Benzol Treatment in Leukemia," S. W. Sappington, M.D.; "Large Sarcoma of Forearm," E. B. Guie, M.D.

The meeting proved to be a very interesting one, and was well attended.

Benj. K. Fletcher, M.D., Secy.

**The Philadelphia Society for Clinical Research**, held its regular monthly meeting on Tuesday evening, May 27th, 1913, at nine P. M., at the office of Doctor G. Harlan Wells, 1807 Chestnut Street. "Radiograph in Internal Diagnosis" was heartily discussed at this meeting. There was a large attendance of members, and an enjoyable time was had by all present.

Percy A. Tindall, M.D., Secy.

**The Homœopathic Medical Society of the 23rd Ward of Philadelphia,** held its regular monthly meeting at "Wyndham," Ambler, Pa., on Wednesday, May 21st, 1913, at three P. M. Some very interesting papers were presented for discussion, after which dinner was served. A very enjoyable time was had by those present, the members being the guests of the Doctor Samuel Sleath.

John D. Boileau, M.D., Secy.

**The Women's Homœopathic Medical Association of Pittsburgh Pa.,** held its regular monthly meeting at the office of Doctor Lydia B. Pierce, 5661 Beacon Street, Pittsburgh, on Thursday, June 5th, 1913, at 8 P. M. Doctor Anna Varner read a paper on "Diseases of the Gall Bladder," which was very interesting, and well presented, after which a discussion on "Hay Fever" took place. Keen interest was shown at this meeting by a large number of members present.

Lydia B. Pierce, M.D., Secy.

**The Delaware County Homœopathic Medical Society** held its regular monthly meeting on Thursday, May 8th, 1913, in the staff-room of the J. Lewis Crozer Homœopathic Hospital, Chester, Pa., at 3.30 P. M. The election of officers for the ensuing year took place at this meeting. There was a large attendance of members, and the meeting was an interesting one.

G. C. Webster, M.D., Secy.

**The West Jersey Homœopathic Medical Society** held its regular monthly meeting at Vineland, on Tuesday, May 20th, 1913, at eleven o'clock, in the morning. The members were the guests of the New Jersey Training School for Feeble-Minded Boys. The exercises which took place were very interesting, and the addresses explaining the work at the institution was an enjoyable feature of the occasion. Many important business matters were discussed at this meeting, and keen interest was shown by all present.

T. E. Parker, M.D., Secy.

**Colorado's Attractions.**—For the information of the profession of New England, New York, New Jersey, Pennsylvania, and other Eastern States the Transportation Committee takes no little pleasure in stating that for the Institute this year there will be such a number and variety of side-trip attractions as have not before been within reach of the members at any session, not even excepting the meeting held in California three years ago.

The Rockies are at once the Alps, Pyrenees and Himalayas of America. From Denver eight lines of railway penetrate the vastness of their ranges, climbing into clouds and amid such a maze of scenic grandeurs as to defy description. During Institute week the body will attend to business, except as its sessions may be limitedly broken in upon by the arrangements of the local committee for the proper local entertainment and pleasure of the visitors. But the week ended, the real pleasure will begin. Every line leading out into the interior, and those running skyward from Colorado Springs, have been invited and have pledged to have their very best attractions presented to the Institute by their own representatives at the Albany Hotel during the week of the sessions. The Transportation Committee has sedulously avoided involvement with any favorites. Every scenic line in the State will have ample opportunity, upon equal footing, of laying before the members its own scenic beauties and grandeurs. The magnificent Triennial Conclave of the Knights' Templar of America is to convene a month following the

Institute. It is expected a full hundred thousand Knights will attend. The selection of Denver for this conclave, king among American pageants, tells a story of Denver's climate in the sizzling month of the year in the East. Never over warm, Denver is always delightfully cool in the evening and her nights are glorious. Snow-capped peaks and great saddle-backs are in sight all the time, cooling breezes from the range making Denver an exceptionally pleasant convention city.

Following the Institute meeting there will be excursions out on the Moffat Line, over the backbone of the continent, to Steamboat Springs, and entertainment at that charming point; outings on the Switzerland Trail of America, whose sobriquet speaks its scenic charms; up to Silver Plume, Idaho Springs and Georgetown, through Clear Creek Cañon and over the famous Georgetown Loop; out to South Park and the very "Heart of the Rockies"; down to Royal Gorge and over Marshall Pass to the Black Canon of the Gunnison; from Colorado Springs up the cog-wheel railway to the top of Pike's Peak, 14,107 feet above the sea; from the same beautiful city to Cripple Creek and Victor by way of the scenic Short Line, where "Heaven and earth are bound together by bands of steel"; over the top of the world on the Colorado Midland, with its splendid mountain views, its beautiful mountain lakes and splendid fishing streams, its Buena Vista and Glenwood Springs; out to Crystal Park over the most perfect mountain automobile pike in the world; "Around the Circle from Montrose to Telluride, Durango, Toltec Gorge, La Vita Pass and Cumbre; from Montrose up to Ouray, the most charming spot in the Rockies if there is one entitled to the distinction, thence by the old Mears stage road to Silverton amid beauties and grandeurs that challenge description; then on down the incomparable Las Animas Canon to Durango.

For members who love valley and glades and dells and splendid orchards and fine berry patches and great alfalfa fields and luxuriant meadows and gardens, Canon City, Montrose, Grand Junction, Pallisades and many other sections have wondrous pleasures in store. And if it is mines the members "are after seeing," Cripple Creek, Victor, Leadville, Silverton, Creede, Central City, Silver Plume and scores of other "camps" are ours for the going. Particularly of interest just now should be the carnotite mines of Gilpin, Montrose, Mesa and San Miguel counties, from which near four millions in uranium oxide and kindred radioactive metals were extracted last year. So valuable are growing the radium interests of Colorado that it is becoming known as the Radium State. It now exceeds Austria in annual out-put of radium-bearing pitchblende, and the United States Government has recently instituted a Radium Bureau in the offices of its Geological Survey corps in Denver.

Briefly, these are a few of the attractions offered the Institute this summer. The Transportation Committee has in the hands of the railway printer at this time a very complete Institute booklet which will interest and please the members, it is believed, in which are set forth at greater length and more in detail the special features of each particular side-trip route and each particular section of the State. Come to Colorado this summer, Institute Members, not only to aid in the resuscitation of a quiescent homœopathy in the Great West, but also to spend a fortnight or month in our glorious Rockies. It will repay you in enjoyment, exhilaration, recuperation and education.

C. E. Fisher, M. D..



# THE HAHNEMANNIAN MONTHLY NEWS AND ADVERTISER

A Medical Newspaper

JULY, 1913

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**Progressive Medicine.**—A Quarterly Digest of Advances, Discoveries and Improvements in the Medical and Surgical Sciences, Edited by Hobart Amory Hare, M.D., Professor of Therapeutics and Diagnosis in the Jefferson Medical College Hospital, etc., etc. Assisted by Leighton F. Appleman, M.D., Instructor in Therapeutics, Jefferson Medical College, Philadelphia, etc., etc. Volume II, June, 1913, "Hernia," "Surgery of the Abdomen, Exclusive of Hernia," "Gynecology," "Diseases of the Blood," "Diathetic and Metabolic Diseases," "Diseases of the Spleen, Thyroid Gland, Nutrition and the Lymphatic System," "Ophthalmology." Lea & Febiger, Philadelphia and New York. \$6.00 per year.

In these days when medical literature is so voluminous, the general medical practitioner and the specialist alike, appreciate the value and importance of condensed resumes of the views of the most experienced writers in the various departments of medical science.

The method followed out in *Progressive Medicine*, namely, the pre-

sentation and critical review of the best articles that have appeared in certain departments of medicine by writers of international reputation, is a particularly happy and practical one. There are few medical publications that will repay the reader for the time and money expended as well as this work.

The volume now before us contains an exhaustive review of the literature of hernia, by William B. Coley, in which he has presented the latest and most progressive thoughts on this important subject.

"Gynecology" is presented by Dr. John G. Clark, "Ophthalmology" by Dr. Edward Jackson, and Dr. Alfred Stengel has reviewed the literature on "Diseases of the Blood" and of the "Ductless Glands."

**A Practical Guide to Homœopathic Treatment.**—Designed and arranged for the use of families, prescribers of limited experience and students of homœopathy, By Myron H. Adams, M.D., consulting physician to the Rochester Homœopathic Hospital, member of the New York State Homœopathic Medical Society. Price, \$2.00. Philadelphia: Boericke & Tafel.

In publishing this volume the author has endeavored to present a work that will serve as a guide to laymen and students for the proper application of homœopathic methods in the treatment of the sick. The opening chapters are devoted to a presentation of the principles of homœopathy and the general methods to be followed for the selection and application of the homœopathic remedy.

Part II is devoted to a discussion of a large number of diseased conditions. A brief review of the nature and symptomatology of the diseases is given followed by a description of the remedies and their indications.

Part III is devoted to the subject of *materia medica*. Almost all the common drugs are taken up and their action and indications perfectly described. It is, of course, a mooted question to-day as to whether it is wise to encourage self-medication on the part of the average layman. It must be admitted that a work of this character would undoubtedly find a valuable place in the library of persons living in situations comparatively inaccessible to the physician. Such communities, however, are very rare at the present time and therefore, we cannot but feel that the legitimate demand for a work of this character is rather limited. The work itself is an excellent one and we would not hesitate to recommend it to those who feel the necessity for assuming the management of illness among their friends or families.

**Massage: Manual Treatment Remedial Movements.**—History, Mode of Application and Effects; Indications and Contra-indications. By Douglass Graham, M.D., Consultant and Instructor in Massage, Boston, Mass., Member of the American Association for the Advancement of Science, etc., etc., with a chapter on Massage of the Eye, by Dr. A. Darier, Paris, formerly President of the Ophthalmological Society of Paris, etc. Fourth Edition, revised and enlarged with 75 illustrations. Philadelphia and London: J. B. Lippincott.

Since the publication of the first volume of this work in 1884, the uses of massage have increased to such an extent that a comprehensive presentation of the subject has required an enlargement of the work until it is now a book of a considerable size. Dr. Graham's work is

largely a record of his personal experiences, combined with the views of the best writers and practitioners of massage both at home and abroad. It partakes of the nature of Text-book and Reference Handbook at one and the same time.

The subject is presented in complete detail and the work is unquestionably one of the most practical and reliable publications on the subject that has appeared in the medical literature.

**The Accessory Sinuses of the Nose, Catarrhal and Suppurative Diseases.**—By Ross Hall Skillern, M.D., Professor of Laryngology at Medico-Chirurgical College, Philadelphia. Cloth, \$5.00. J. B. Lippincott, Philadelphia and London.

This is undoubtedly the most thorough and exclusive work on this subject in the English language. While all treatises on Rhinology contain chapters on Sinus disease, this is the first book printed on this side of the Atlantic devoted to this subject alone.

The book is profusely illustrated, there being 247 engravings and five colored plates, most of these are the author's own, in which he had as collaborators, Messrs. E. F. & Ludwig Faber.

Following after a simple but clear anatomic description of the sinuses and their relation to the nostrils and a general consideration of the bacteriology and pathology, each sinus is considered separately and its diseased conditions handled in minute detail as to diagnosis and treatment. The indications for the various operations are given, and the operative technique is very graphically described, each operation being illustrated in its various steps by separate drawings. This is essentially a book for specialists.

Wm. M. Hillegas.

**Medical Union Number Six.**—By William Harvey King, author of "My Smoking Room Companion." 60 pages. Cloth. Philadelphia. Boericke & Tafel. Price, 50 cents.

This piece of fiction deals with the days when the medical profession has become organized into a national union. It is a story of offensive and defensive alliance. The description of the methods employed by the profession in enforcing their demands is very interesting reading.

**Diet Lists of the Presbyterian Hospital, New York City.**—Compiled, with notes, by Herbert S. Carter, M.D., Assistant Visiting Physician to the Presbyterian Hospital, Associate in Medicine at Columbia University, etc. 12mo. of 129 pages. Philadelphia and London: W. B. Saunders Company, 1913. Cloth, \$1.00 net.

This book is not a text-book on diet but merely a publication of the diet lists used in the Presbyterian Hospital, New York City. We regard it as a very practical and valuable work and much superior to many of the prolonged dietetic discourses that are often foisted on the profession and which furnish very little food for rational thought.

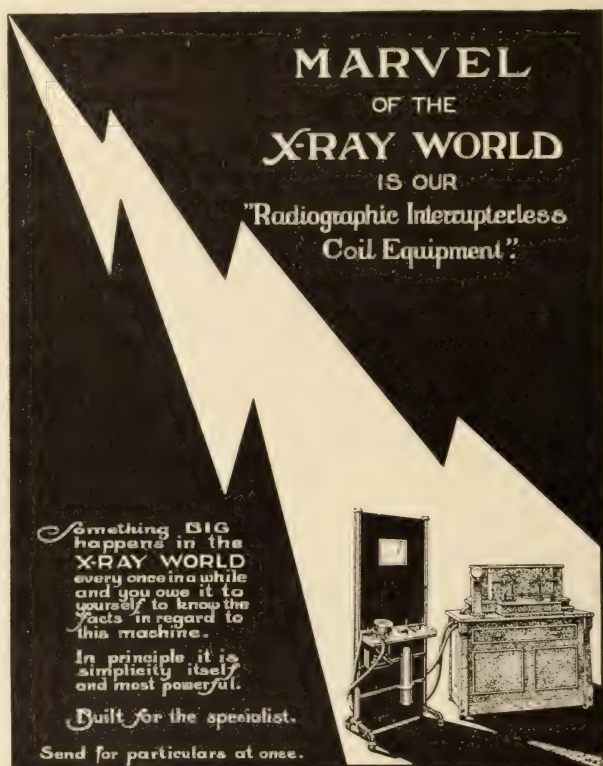
**Mueller's Serodiagnostic Methods.**—Authorized Translation from the Third German Edition, by Ross C. Whitman, B.A., M.D., Professor of Pathology, University of Colorado School of Medicine. With seven illustrations in text. Philadelphia and London: J. B. Lippincott.

Professor Miller's clear presentation of the complicated methods



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embraced under the term Sero-Diagnosis cannot fail to find a welcome among the rapidly increasing number of physicians who are interested in this work. Among the important sero-diagnostic measures mentioned, we note the Wassermann test, the Widal test, the Cancer Diagnosis of Freund and Kaminer, the Cystolic Reaction for diagnosis of pregnancy, Tuberculin Diagnosis, Anti-fermentive Reactions, etc. The work is a concise and authoritative summary of our present knowledge of this growing and important subject.

**The Psychoneuroses and Their Treatment, by Psychotherapy.**—By Professor J. DeJerine, Professor of the Clinic for Nervous Diseases of the Faculty of Medicine of the University of Paris, and Dr. E. Gauckler. Authorized translation by Smith Ely Jelliffe, M.D., Ph.D. Adjunct Professor of Diseases of the Mind and Nervous System, Post Graduate Medical School and Hospital, etc., etc. Price, \$4.00; Philadelphia and London: J. B. Lippincott Company.

It is probable that most physicians who have been in practice for many years have been struck with the slight degree of success which results from the treatment of neuropaths by medicines, combined or not with physical measures. During recent years the profession has gradually come to recognize the fact that unless the mind of the patient suffering from that group of symptoms universally known as *neuresthenia* or *hysteria*, is improved, the therapeutic results are far from being permanent or satisfactory, no matter what medicinal or physical agent has been employed.

For more than thirty years Dr. DeJerine has given his time to the study and treatment of patients suffering from psychoneurosis and in this volume has given us the result of his experiences with the use of psychotherapy in the treatment of such conditions. The author has especially uncovered the emotional factors which are present in all of the group of disorders referred to and in his work has presented this subject in a very able and practical manner. To most physicians this department of therapeutics is entirely unknown. We can only say that it is one worthy of careful investigation. A practical knowledge of the psychic treatment of nervous disorders is absolutely essential to the progressive physician in these days when patients suffering from functional nervous disorders have become so numerous.

**Blood Pressure in General Practice.**—By Percival Nicholson, M.D., with seven illustrations. Philadelphia and London: J. B. Lippincott Company. Price, \$1.50.

The author of this volume has endeavored to furnish the general practitioner and surgeon with a short treatise on blood pressure from the standpoint of its practical significance and value. After describing the technique of the various types of instruments employed, the author next sets forth the factors upon which blood pressure depends. Physical and pathological variations of pressure are then taken up and other clinical significance discussed. The relation of blood pressure to surgery and to life insurance is also fully presented.

**Homœopathy in Medicine and Surgery.**—By Edmund Carleton, M.D. 311 pages. Cloth, \$2.00 net. Postage, 15 cents. Philadelphia. Boericke & Tafel, 1913.

In this work the author has endeavored to hand down the fruits of his experience of over forty years in the practice of pure homœopathy. He has presented his material in a series of practical cases, bringing the patient and sick room to the foreground as vividly as possible. His constant aim has been to show that individualism is the crux of homœopathic practice.

A large variety of medical and surgical diseases are taken up and after a general discussion of the diseases with a presentation of typical cases, a brief summary of the indications of commonly used remedies is given. The work is of an eminently practical character and the author has succeeded in presenting the subject in a very interesting manner.

**"When to Send for the Doctor and What to Do Before the Doctor Comes."**

—By Frieda E. Lippert, M.D., Assistant at the Psychological Clinic, University of Pennsylvania, and Arthur Holmes, Ph.D., Assistant Professor of Psychology and Assistant Director of the Psychological Clinic, University of Pennsylvania. Sixteen full-page illustrations and frontispiece in color. Philadelphia and London: J. B. Lippincott Company.

This work is designed for parents, teachers and social workers and it is the intention of the authors to present in a simple manner the symptoms of common ailments and their methods of treatment. In the words of the authors "The book tells when **not** to send for the doctor and exactly **when** to send for the doctor and what to do in emergencies before the doctor comes."

While the work is one that contains much useful information we regard it as a dangerous one to place in the hands of the laity. For example, in discussing chicken pox, the authors state that it is not necessary for a physician to be called and yet every physician is aware of the fact that it is easily possible for the inexperienced to confuse chicken pox with smallpox. Likewise under sore throat, unless the mother sees a diphtheritic deposit on the tonsil or soft palate, the advice of a physician is not considered necessary.

This advice is given in spite of the fact that numerous cases of diphtheria occur in which "film" in the throat may be entirely absent or very difficult to discover. Advice of this character renders useless what would otherwise be a valuable and helpful work.

**The Operating Room and the Patient.**—Third Edition rewritten and enlarged. By Russell S. Fowler, M.D., Chief Surgeon, First Division, German Hospital, Brooklyn, New York. Octavo volume of 611 pages with 212 illustrations. Philadelphia and London: W. B. Saunders Company, 1913. Cloth, \$3.50 net.

This volume deals with the preparation of the patient before the operation, and with the technique and general handling of the case in the operating room and with the post-operative treatment and complications.

It is a volume of more than six hundred pages and is much more comprehensive in its character than the title would suggest. It is a work which has proven very popular and furnishes a good deal of useful information that is not easily obtainable in the ordinary text-book of surgery.

**Clinical Laboratory Methods.**—A Manual of Technique and Morphology



Designed for the Use of Students and Practitioners of Medicine.—By Roger Sylvester Morris, A.B., M.D., Associate Professor of Medicine in Washington University, St. Louis. Formerly Associate in Medicine, the Johns Hopkins University; Assistant Resident Physician, the Johns Hopkins Hospital; Instructor in Medicine and Demonstrator of Clinical Medicine, The University of Michigan. D. Appleton & Company, New York and London.

During recent years there has been a wide-spread interest in the use of clinical laboratory methods as aids to diagnosis. Not only is this true in a case of recent graduates in medicine, but older practitioners are generally realizing the necessity of the laboratory in their daily work.

The volume now before us is a manual of laboratory technique. It gives in detail the methods of examining the urine, gastric contents, feces, blood, sputum and puncture fluids. This is a work which appeals especially to the student and medical practitioner. The author has eliminated all uncertain and doubtful procedures and has presented only those methods of examination that have stood the test of practical experience. The text is concise and accurate and we can recommend the work highly to those desiring the latest information on this subject.

**International Clinics.**—A Quarterly of Illustrated Clinical Lectures and Especially Prepared Original Articles on Treatment, Medicine, Surgery, Neurology, Pediatrics, Obstetrics, Gynaecology, Orthopaedics, Pathology, Dermatology, Ophthalmology, Otology, Rhinology, Laryngology, Hygiene, and other Topics of Interest to Students and Practitioners.—By leading members of the medical profession throughout the world, edited by Henry W. Cattell, A.M., M.D., Philadelphia, U. S. A., with the collaboration of John A. Witherspoon, M.D., Nashville, Tenn.; Sir Wm. Osler, M.D., Oxford; A. McPhedran, M.D., Toronto; Frank Billings, M.D., Chicago; Chas. H. Mayo, M.D., Rochester; Thos. H. Rotch, M.D., Boston; John C. Clark, M.D., Philadelphia; James J. Walsh, M.D., New York; J. W. Ballantyne, M.D., Edinburgh; John Harrold, M.D., London; Richard Kretz, M.D., Vienna. With regular correspondents in Montreal, London, Paris, Berlin, Vienna, Leipsic, Brussels, and Carlsbad. Volume I. Twenty-third series, 1913. Philadelphia and London: J. B. Lippincott Company.

This volume of International Clinics is devoted to "Diagnosis and Treatment," "Medicine," "Pediatrics," "Surgery," "Obstetrics," "Electro Therapeutics."

The article by Abrams on "The Treatment of Aneurisms" brings forward many new ideas on this subject, and, unless the optimism of the author has been very misleading, we possess in spinal percussion a therapeutic measure of great value in the management of this intractable condition.

Walsh contributes a very valuable article on "Disease Simulation" which should be of particular interest to the neurologist and general practitioner.

McArthur's article on the "Transplantations of the Tissues" contains much that is new and of interest from a surgical standpoint.

**Chloride of Lime in Sanitation.**—By Albert H. Hooker, Technical Direc-

tor Hooker Electrochemical Company. New York, John Wiley & Sons, London: Chapman & Hall, Limited.

This volume contains a complete report of the methods of manufacture and uses of chloride of lime as a disinfectant.

**Text-Book of Physiology.** By Isaac Ott, A.M., M.D., Professor of Physiology in the Medico-Chirurgical College of Philadelphia, etc., etc. Fourth Edition, revised and enlarged. Illustrated with 434 half-tone and other engravings, many in colors. Publishers, F. A. Davis, Philadelphia.

This work which was originally designed for the use of students, has steadily grown until in this, its fourth edition, it represents a very complete and comprehensive review of the subject of physiology.

The author has added a great many new plates, some of which have never appeared in any English text-book of physiology. The plates showing movements of the intestines as demonstrated by radiographic methods are particularly interesting and instructive.

The section relating to the ductless glands contains a great deal of new and valuable information. The work contains almost four hundred illustrations illustrative of the text and in its present form can be relied upon as a comprehensive and authoritative guide to the student or practitioner desiring information in this branch of medical science.

**Private Nursing.**—By Katharine DeWitt, R.N., Graduate of Mt. Holyoke Seminary and of the Illinois Training School for Nurses; Assistant Editor of the "American Journal of Nursing." Philadelphia and London: J. B. Lippincott Company.

In this little work the writer has endeavored to show the new graduate how to apply in the home the knowledge she has gained in the hospital. It is a book which every nurse would do well to read.

**Don't Be A Faddist.**—Eat - Drink - And - Live - Long. (Common Sense Suggestions for Ordinary Diet and Hygiene.) By E. O. Richberg, M.D., Lecturer on Diet and Hygiene, etc., etc. Philadelphia, Boericke & Tafel.

During recent years innumerable dietetic theories have been advanced, most of which have found a great many victims among the American public.

The present volume is a protest against food faddists and the author has endeavored to state in a practical way some valuable and definite facts in regard to this important subject.

**Diseases of the Stomach, Including Dietetic and Medicinal Treatment.**—By George Roe Lockwood, M.D., Professor of Clinical Medicine in the Columbia University; Attending Physician to Bellevue Hospital, New York. In one octavo volume of 624 pages, with 126 engravings and 15 plates. Cloth, \$5.50, net. Lea & Febiger, Philadelphia and New York, 1913.

The diseases and disorders of the stomach form a large part of the work of every general practitioner. They are, fortunately, a class of malady in which scientific treatment can be made especially efficacious, because of the location of this organ and the nature of its functions. In

this new work the author gives the most modern views on all phases of the subject, and has made a feature of medicinal and dietetic treatment. The book represents an original study of a large number of cases from the author's private and hospital records, so that it conveys to the reader the substance of his large experience. Illustrations and plates have been freely used wherever it was possible to elucidate the text.

**The Modern Treatment of Nervous and Mental Diseases.**—By eminent American and British authors. Edited by William A. White, M.D., Superintendent of the Government Hospital for the Insane, Washington, D. C.; Professor of Nervous and Mental Diseases in the Georgetown University and in the George Washington University; Lecturer on Mental Diseases in the U. S. Army and U. S. Navy Medical School, Washington, D. C., and Smith Ely Jelliffe, A.M., M.D., Ph.D., Adjunct Professor of Diseases of the Mind and Nervous System in the Post Graduate Medical School and Hospital; Visiting Neurologist to the City Hospital; Consulting Neurologist to the Manhattan State Hospital, New York, N. Y. Two octavo volumes, containing about 900 pages each, illustrated. Per volume, cloth, \$6.00, net. Lea & Febiger, Publishers, Philadelphia and New York, 1913.

The second volume of this unique work has made its appearance within a few weeks after the publication of the first. It deals with matters of great interest and extreme practical value, and its pictorial department is fully up to the high standard of the text. Among the many subjects discussed are the Neuralgias and Neuritides, Injuries of the Peripheral Nerves, Muscular Atrophies and Dystrophies, Headaches, Spasmodic Disorders, Epilepsies, the Meningitides, Syphilitic Diseases of the Nervous System, the Use of Salvarsan and Neosalvarsan, Cerebral Hemorrhage, Embolism and Thrombosis, Disorders of Expression, Stuttering, Diseases of the Cranial Nerves and Lesions of the Spinal Cord, Diseases of the Optic Thalamus, Midbrain and Cerebellum, Paralysis Agitans and Multiple Sclerosis, the Toxemias of Dangerous Trades and of Drugs, and the Surgery of the Brain and Spinal Cord. In these two volumes the practitioner now has, in most convenient form, the latest and best knowledge concerning a very puzzling and difficult class of cases.

**Homœopathic Medical Society of Kings County.**—The four hundred and sixty-seventh meeting of the Homœopathic Medical Society of the County of Kings, was held June 10th, and two very interesting papers occupied the evening. The first, by Dr. Walter Gray Crump, of New York, was entitled "Post Operative Abdominal Adhesions and Sepsis. Some Ideas as to Their Prevention and Treatment." Dr. Crump dwelt upon the uses of camphor in abdominal sepsis calling attention to the apparent similitum between the effects of camphor in its provings and the conditions found in septic peritonitis, and reciting experiences in the use of that remedy in combination with oil, in varying strengths, as a preventive of adhesions in abdominal inflammations. He also mentioned the use of neutral animal oils as preventives of adhesions in inflammatory conditions of the peritoneum. In discussing the paper, Dr. Iler, of the Cumberland Street Hospital, spoke of a paper recently published by Dr. Patrick, of Boston, on the uses of camphor in the treatment of septic conditions of the skin, especially in stitch abscesses,



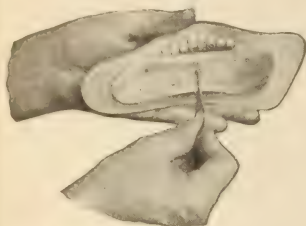


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and where unhealthy skin wounds did not respond to ordinary treatment.

Prof. Soresi, of the New York Homœopathic Medical College, presented a paper entitled: "Prevention of Death, and Resuscitation." The paper was an analysis of the professor's work in vivisection upon dogs to study the effects of hemorrhage, shock, gas poisoning, and auto-intoxications. He claimed that many deaths could be prevented in acute diseases if transfusion of blood could be made from a healthy individual. He has bled dogs to such a degree of lifelessness that they were actually stiff and practically dead, and then by transfusion of blood from a live dog the apparently dead animal returned to life. He mentioned one case where a patient was dying from a severe pneumonia, and when the brother begged that something be done to save the patient, Dr. Soresi opened the jugular vein of the sick man and made a transfusion of blood from the brother direct, with the resulting recovery of the patient. He stated that it is a simple matter to get blood into the right side of the heart by way of the jugular vein and superior vena cava, but so far it had not been possible to get blood to the left side of the heart. If the latter could be accomplished and healthy blood be delivered from the left ventricle throughout the body, death could frequently be prevented in acute diseases. The one essential in all transfusion work was that the organs must be in good condition and the central nervous system not impaired. In Bright's disease, where the kidneys were impaired, attempts had been made to transplant a healthy kidney, leaving the original kidneys in place so that the animal had three kidneys, with the ureters attached to the bladder. It had not been tried in human beings yet, and he could not advise it at the present time. In gas poisoning, in young people especially, by transfusion every case should be saved. In elderly people with arterio sclerosis or organic lesions there was nothing to be done.

L. D. Broughton, M.D., Secy.

#### PENNSYLVANIA STATE NOTES FOR AUGUST, 1913.

The Homœopathic Medical Society of the County of Philadelphia, held its regular monthly meeting at Hahnemann College, on Thursday evening, June 12, 1913, at 8.30 o'clock. The scientific program consisted of the following: "A Talk on the Revision of the Pharmacopoea," T. H. Carmichael, M.D.; "Practical Demonstration of the Administration of Salvarsan," W. C. Hunsicker, M.D.; "Refractive Errors as a Case of Obscure Symptoms," Percy A. Tindall, M.D.; "The X-Ray as an Aid to Internal Diagnosis," G. Harlan Wells, M.D.

The election of officers took place at this meeting which was as follows: President, Doctor Herbert Leopold; first vice-president, Doctor Warren Mercer; second vice-president, Doctor W. D. Culin; secretary, Doctor Wm. M. Sylvis; treasurer, Doctor I. B. Gilbert; trustees: Doctors Weston D. Bailey, N. F. Lane, L. T. Ashcraft, C. S. Raue, and Norman Betts. Censors: Doctors Nelson Hammond, Joseph Caley, and J. Mansfield. Keen interest was shown at this meeting by a large number of members who were present.

Wm. M. Sylvis, M.D., Secy.

The Homœopathic Medical Society of the 23rd Ward of Philadelphia, held its regular monthly meeting on Wednesday, June 18th, at the Hotel "Phoenix," Willow Grove, Pa. An interesting paper entitled "Some

Clinical Tests" was read by Doctor J. B. Bibighaus, and was very ably presented. The meeting was largely attended, and an enjoyable time was had by those present.

John D. Boileau, M.D., Secy.

The Germantown Homœopathic Medical Society held its regular monthly meeting at the "Majestic," Broad and Girard Avenue, on Monday, the sixteenth of June, 1913, at nine o'clock in the evening. A paper on "Hay Fever" was read by Doctor Wm. M. Hillegas, after which a hearty discussion took place. There was a full attendance of members, and a pleasant time was had by those present.

Landreth W. Thompson, M.D., Secy.

The West Philadelphia General Homœopathic Hospital and Dispensary Staffs held their regular monthly meeting on Monday evening, June 23rd, at 1234 No. 54th Street, at 9 P. M. Many matters of importance were discussed at this meeting, and great interest was shown by those present.

S. W. Reeves, M.D., Secy.

**Homœopathic Graduates Five.**—Five nurses became graduates of the Reading Homœopathic Hospital and Training School at the sixteenth commencement exercises, which were held in St. Paul's Reformed Church, on Thursday evening, May 29th. They were Misses Mable Esterly, Nora Huyett, Florence Houck, Winona Wolf, and Lilliam McElwain. The diplomas were presented by C. H. Ruhl, Esq. Doctor D. C. Kline and Rev. Dr. J. H. Hackenburg were the speakers. After the exercises there was a dance at the Nurses' Home.

**A Systemic Boost.**—It is safe to say that the average physician is called upon to prescribe a tonic more frequently than any one other form of medication, unless it be a cathartic. Patients who are patients solely because they are tired, "run down" and generally debilitated, are constant visitors at the physician's office. Such individuals need something that will boost them up to their normal point of resistance and then hold them there; in other words, not a mere temporary stimulation, with secondary depression, but a permanent help to the revitalization of the blood and a general reconstruction. Pepto-Mangan (Gude) is not only prompt in action as an encourager of appetite and better spirits, but is also distinctly efficient as a blood builder and systemic reconstituent. It is pleasant, non-irritant, free from constipating effect and does not stain the teeth. It is thus a general constitutional tonic of positive service in all conditions of general devitalization.

The Homœopathic Medical Society of Chester, Delaware and Montgomery Counties, held their summer meeting at the Plymouth Country Club, Norristown, Pa., on Tuesday, June 10, 1913. An inspection of the State Hospital for the Insane was made under the direction of the resident physicians S. M. Miller, M.D., and A. K. Petry, M.D. Many of the members then participated in playing golf and tennis, after which luncheon was served. The meeting was largely attended, and a royal time was had by those present.

Isaac Crowther, M.D., Secy.

**Personals.**—Dr. S. R. Klein, of New York, has opened an up-to-date pathological and bacteriological laboratory at the Sayre Private Hospital, 45 South First Avenue, Mt. Vernon, N. Y.

Doctor Benjamin K. Fletcher announces the removal of his offices



to 319 South Sixteenth Street, Philadelphia. Hours: 8 to 10 A. M.; 5 to 7.30 P. M. Sunday, 9 to 11 A. M. only.

Doctor John G. Wurtz announces the opening of his new Clinical Laboratory, 2103 North Howard Street, Philadelphia. Urinalysis, Blood Counts, Widal's, Gastric Analysis, Bacteriological and other laboratory tests. Drawings and Charts. Specimens received at 2103 No. Howard Street, or 1621 Arch Street.

**Goodno Medical Society.**—The June meeting of the Goodno Homœopathic Medical Society was held at York Medical Club, on June 12th. There were eighteen members present. A buffet luncheon was served at which the Society was the guest of the York County members. The first paper was read by Dr. George W. Brose, of York, on "Instrumental Delivery"; the second paper was read by Dr. J. A. Shower on "Vomiting in Pregnancy." Both of these papers brought out free and lively discussion by nearly all members present.

The guest of honor was N. R. Perkins, of Boston, Mass., a member of the Massachusetts State Board. He gave us an excellent talk on the research work done by Dr. Nowell, of the Boston University, about his cancer serum. He also had a demonstration of the pulmotor under the direction of Dr. B. F. Parker, W. E. J. Bomberger, Secy.

**Hay Fever: "Disease of Mystery."**—Discussing the problems of etiology and treatment, Dr. Hogsett says: "Many theories have been elaborated, and many forms of treatment have been called to the attention of the medical profession. A strain of pessimism regarding the possibility of a cure in this condition appears in the writings of many authors. No one theory accounts for all features of the affection and the many etiological factors."

In 1912, Dr. Hogsett treated a number of cases successfully with Mixed Infection Phylacogen. His observations as to methods and results are of interest and value. "In carrying out the Phylacogen treatment," he says, "I have found that the initial dose should be small when given either subcutaneously or intravenously. It has been my procedure to begin with a 2 c. c. dose subcutaneously or one-half c. c. intravenously. . . In giving the subcutaneous injection I usually select the insertion of the deltoid or the area just below the scapulae. The latter seems to be the ideal spot, as absorption takes place very readily and the complaints from the local reaction are much less. I repeat my injection either daily or on alternate days, the interval to be determined by the clinical condition of the patient. It is seldom necessary to give more than four to six injections the symptoms often disappearing after the second or third injection. Almost immediate relief is noted by the patient. The irritating discharges from the eyes and nose are diminished in amount, the sneezing is lessened, the dyspnea is relieved, and the patient usually sleeps comfortably. All cases that I have treated successfully have remained well through the season. I have yet to record only one failure, but I have not had a sufficient number of this class of cases as yet to warrant a positive claim that this remedy will act in all forms of the disease."

Clinical experience with Mixed Infection Phylacogen in the treatment of hay fever is inconsiderable as yet. The product had its inception in 1912, when the season was well advanced, and the opportunities for its employment were necessarily limited. The next two months will

undoubtedly tell the story of its applicability to this hitherto intractable disease, and the results of a more extended trial will be watched with a deal of interest.

**Homœopathic Medical Society of Reading.**—A stated meeting of the Hahnemann Medical Society was held at the Homœopathic Hospital, Friday evening, June 6th. Dr. C. B. Jennings presided at the meeting.

Dr. A. S. McDonnell read a very interesting paper on "Salpingitis," after which there was a general discussion. Dr. D. C. Kline was appointed speaker to represent the Society at the joint meeting to be held at Rittersville, on June 19th. The secretary was appointed essayist for the next meeting.

Frank H. Lawrence, M.D., Secy.

**An Ally Worthy of Confidence.**—It is going on toward twenty years since Gray's Glycerine Tonic Comp. was first placed at the service of the medical profession. During all this period Gray's Glycerine Tonic Comp. has maintained the standards that first attracted attention and the busy practitioner has ever found it an ally worthy of confidence. It never disappoints and in the treatment of atonic conditions, particularly of the gastro-intestinal tract, it is often the one remedy that will produce tangible and satisfactory results. The physician who does not use it in his practice is denying his patient many benefits that can be obtained in no other way.

**Chronic Catarrhal Diseases.**—Chronic catarrh never fails to indicate general constitutional debility. Local treatment is always desirable but for permanent results efforts must be directed toward promoting general functional activity throughout the body, and a general increase of systemic vitality. The notable capacity of Gray's Glycerine Tonic Comp. in this direction readily accounts for the gratifying results that can be accomplished through its use in the treatment of all chronic catarrhal affections, but especially those of the gastro-intestinal canal and respiratory tract. The particularly gratifying features in the results accomplished by Gray's Glycerine Tonic Comp. are their substantial and permanent character. This is naturally to be expected since they are brought about through restoring the physiologic balance of the whole organism.

**To Promote Digestive Tone.**—When the functional activity of the digestive tract has been impaired by concomitant diseases, and on this account, the nutritive processes are unable to serve the body effectually, Seng is always indicated. This preparation is derived from Panax (Ginseng) and is pleasant to take as well as promptly active in enticing an appetite, gently stimulating the flow of digestive secretions, and giving tone to the organs of digestion generally. Seng acts along the line of "physiological suggestion" rather than as a substitute for the digestive ferments. In other words, it promptly stimulates the secretory activity of the stomach and intestines, so that there is a speedy return to normal physiological functioning. The dose, one to two teaspoonfuls, may be administered before or during a meal. When given alone, it is preferably administered in a small amount of water. The significance of loss of appetite as a forerunner of many serious diseases, is well appreciated by the astute diagnostician and clinician. It is in such instances that Seng is valuable in greatest measure as a dependable prophylactic. By stimulating flagging digestive and assimilative functions in the beginning, it often prevents what would surely be serious and intractable nutritional disorders later.

# THE HAHNEMANNIAN MONTHLY NEWS AND ADVERTISER

A Medical Newspaper

AUGUST, 1913

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**A Text-Book of Biology.—For Students in Medical, Technical and General Courses.**—By William Martin Smallwood, Ph.D., (Harvard), Professor of Comparative Anatomy in the Liberal Arts College of Syracuse University, and in charge of Forest Zoology in the New York State College of Forestry at Syracuse. Octavo, 285 pages; illustrated with 243 engravings and 13 plates, in colors and monochrome. Cloth, \$2.75, net. Lea & Febiger, Publishers, Philadelphia and New York, 1913.

Biology is now recognized as one of the fundamental sciences in the study of medicine, and most of the medical colleges of this country either require a knowledge of it for entrance, or include, it as part of the preliminary instruction. This has given a new stimulus to the teaching of this subject, and has awakened a broader interest in it than ever before. The appearance of a new text-book, written in accordance with the most modern ideas, and designed to meet the needs of the medical student, is therefore timely. Professor Smallwood's work is unique in the excellence of its instruction and the high standard of its numerous illustrations. The method of imparting the facts leads the reader to think for himself and cultivates his powers of observation—a very important



point. To the physician who graduated before Biology was generally taught in the medical curriculum the book should be of especial interest and value.

**Hygiene and Sanitation.**—A text-book for Nurses.—By George M. Price, M.D., Director, Joint Board of Sanitary Control; Director of Investigation, New York State Factory Commission. 12mo., 236 pages. Cloth, \$1.50, net. Lea & Febiger, Publishers, Philadelphia and New York, 1913.

All medical men have for years realized the great possibilities of hygiene and preventive medicine, and though much good has everywhere been accomplished by the institution of hygienic measures, a great deal remains to be done, and this must be largely achieved through the education of the public. In the attainment of this end no factor is as important as the nurse. Every day she has opportunities to impress upon the laity some of the principles of hygiene and their practical application, and it is therefore one of the most essential elements of her training that she should be well informed on a subject of such universal importance. This new work from the pen of Dr. Price is admirably suited to the needs of the nurse in the discharge of her professional duties and its simplicity of diction renders it equally valuable for home use. It is a work to be recommended to all persons interested in the prevention of the spread of disease.

**Diseases of the Ear.**—By Phillip D. Kerrison, M.D., New York, Professor of Otology, New York Polyclinic Medical School and Hospital. Published by J. B. Lippincott Company, Philadelphia; 569 pages; 333 illustrations. Price, \$5.00

This rather comprehensive book presents the complete subject of otology in the light of recent advances, omitting all discarded theories and old therapeutic measures. The importance and true relationship of labyrinthine conditions and of suppurative lesions of the brain and meninges, are emphasized by the amount of space accorded them. An entire chapter is devoted to the influence of vaccines upon certain phases of disease. It is to be wished that all books on special subjects would deal as fully with the relationship of general diseases. The operations are illustrated by successive steps which are self-explanatory usually, combined with technical explanations that are clear and concise.

**The Annual Convention and Clinic of the American Association of Orificial Surgeons, Chicago, September 23d to 26th, Inclusive.**—All physicians of all schools are invited to attend both. Dr. E. H. Pratt, father of Orificial Surgery, will personally operate and lecture. The Clinic will be under the supervision of a faculty of teachers composed of prominent Orificial surgeons. At the Clinic surgical methods of cure for all chronic diseases will be demonstrated daily: Asthma, Dyspepsia, Paralysis, Eczema, and Rheumatism, as well as diseases that present simply an aggravated attack of local pathology will be treated. It will pay you, Doctor, to attend. Surgeons and general practitioners throughout the country testify that Orificial Surgery applied in everyday practice has added thousands of dollars to their incomes and immensely to their reputations for curing chronics.

As you may know, Orificial Surgery applies particularly to the freeing of sympathetic nerve impingements at the orifices of the body.

Those attending will be taught to recognize and correct Orificial defects.

The Clinic is free. The Association will look after all details in an endeavor to broaden the scope of this great therapeutic measure. The Clinic will be held in the amphitheater of the Francis E. Willard Hospital, 710 So. Lincoln Street, across from the Cook County Hospital.

In the Convention, papers will be read by prominent men upon the Philosophy of Orificial Surgery, its technique, its application in the treatment of refractory chronic ailments. The headquarters for the Convention will be the Hotel La Salle, La Salle and Madison Streets. All its sessions, programs and committee meetings will be held therein. For further particulars you are invited to address the Secretary,

W. A. Guild, M.S., M.D.,

Suite 230, The Utica.

Des Moines, Iowa.

**More Phylacogen Figures.**—"Case histories of 6,324 patients treated with Phylacogens have been sent to us by the attending physicians. They show 5,270 recoveries—83 per cent."

This statement has just been issued over the signature of Parke, Davis & Co., and a very impressive pronouncement it is. If there are members of the medical profession who have been wont to question the therapeutic efficacy of the Phylacogens, that "83 per cent of recoveries" should quickly remove their skepticism.

**A Society of Surgery, Gynecology and Obstetrics**, to be a section of the Philadelphia County Homœopathic Medical Society, has completed its temporary organization. Permanent organization will be perfected in September. All members of the County Society, who are interested in any of the above specialties are invited to become members of this section. Further information may be obtained from the officers.

Temporary Chairman—Dr. G. A. Van Lennep, 1825 Chestnut St.

Temporary Secretary—Dr. J. M. Kenworthy, 1825 Chestnut St.

**Important Notice.**—The Annual Meeting of the Homœopathic Medical Society of the State of Pennsylvania, will be held at the Bedford Springs Hotel, Bedford Springs, Pa., September 2-3-4, 1913. It will be recalled with pleasure by those who had the privilege of being in attendance, that the Society met at Bedford Springs two years ago, and that it was the unanimous opinion of all those present that no more suitable place for the meeting can be found. The Bedford Springs Hotel is delightfully situated on one of the ridges of the Allegheny mountains at an elevation of about four thousand feet. Adjoining the hotel, there is an eighteen hole golf course, tennis court, bowling alley and one of the finest swimming pools in the country. The service of the hotel is fully up-to-date and the committee in charge has made arrangements with the management so that every provision will be made for the comfort and pleasure of the visiting members. All of these features, together with the beautiful scenery and the delightful climatic conditions that usually prevail in this region in the early part of September, contribute a great deal to the social pleasure of the meeting and afford the busy physician an opportunity for pleasurable relaxation as well as for the acquisition of scientific knowledge.

From a scientific standpoint, a very practical and complete program has been announced covering the entire field of medical activity. It is safe to say that it embraces subjects that will be of vital interest and

importance to every homœopathic practitioner in the State. The very radical changes that have taken place in medical education and in medical requirements in this State during the past two or three years are matters which vitally affect the welfare of the homœopathic school



**Hotel Office, Bedford Springs.**

and every practitioner of homœopathy should make an effort to be present in order to learn what these changes have been and to express his opinion as to their effect upon the interests of homœopathy and of the public in general.

Our President, Dr. H. S. Nicholson, and the various committees



**Walk to the Springs.**

appointed by him are doing good earnest work and their appeal recently sent out to every member of our school to become interested "in organized State work because we are approaching a critical time in our existence as a distinct school of medicine and need the moral support of your presence and of your counsel" should meet with a prompt response from every member of the homœopathic school in the State.



**Personals.**—Dr. Carl A. Williams wishes to announce that his office and residence will be located at 207 Mt. Prospect Avenue, Newark, New Jersey, after September 1st, 1913. Hours: 9 to 10 A. M.; 1.30 to 3 P. M., and 7 to 8 P. M. Diagnosis and Internal Medicine.

Doctor William C. Hunsicker announces the removal of his office to 1625 Race Street, Philadelphia. Hours: 9 to 12 A. M.; 5 to 7 P. M. Sundays: 9 to 12 A. M. Genito-Urinary Diseases.

Dr. George J. Alexander announces that hereafter his practice will be limited to the ear, nose and throat in association with Dr. George W. Mackenzie, rooms 900-906 Professional Building, 1831 Chestnut Street, Philadelphia. Hours: 3.30 to 6 P. M. Monday and Thursday 3.30 to 8 P. M., and by appointment.

#### PENNSYLVANIA STATE NOTES.

**Scranton Graduates Eight from Hahnemann.**—On Thursday evening, June 26th, eight young women were graduated from the Hahnemann Hospital Training School for nurses, and were presented with diplomas by Doctor John L. Peck, and received their graduate medals from Mrs. Layton Oakford. David Boise presided at the commencement exercises, and Rev. R. P. Kreidler, pastor of St. Luke's Episcopal Church, made the address of the evening. Miss Ethel Shoemaker was the soloist of the evening, being accompanied by Miss Laura Meldrum. Following the exercises a reception was held at the hospital on Colfax Avenue. The graduates were: Misses Mary and Louise Stone, Catherine Costello, Scranton; Rebecca Douglass, Northumberland; Mabel Quinn, Pittston; Helen Holcond, West Pittston; Mrs. Bessie Ransom, New York City; and Mabel Oliver, Beach Lake.

**New Hospital Thronged on Opening Day.**—The bazaar and supper for the benefit of the Homœopathic Hospital of Chester County, was held at the institution, Walnut and Biddle Streets, West Chester, Pa., on Thursday, July 24th. A great crowd of people attended, and every department was practically sold out by 8.30 o'clock.

All morning, members of the committees, doctors, board members, and others, who were interested, worked unceasingly to arrange the tables on the lawn, with most attractive results.

The hospital was open for inspection and the superintendent, Miss Mary C. Davies, and members of the Board of Managers and Auxiliaries, assisted by five probationers, neatly gowned in pink with the regulation caps and aprons, welcomed the guests and showed them through the building. The interior of the building is practically finished, and each room is furnished and ready for occupancy.

**The Homœopathic Medical Society of the 23rd Ward of Philadelphia,** held its regular monthly meeting at the "Hotel Phoenix," Willow Grove, Pa., on Wednesday, July 17, 1913. Keen interest was shown at this meeting by a large number of members present, and many matters of importance were discussed.

John D. Boileau, M.D., Secy.

**The Southern Homœopathic Medical Association** will hold its annual meeting at Atlanta, Georgia, November 11, 1913. The President, Dr. W. B. Lorraine, has appointed the following chairmen to have charge of

the various bureaus: *Materia Medica*—Dr. Dora Wheat, Louisville, Ky.; *Pedology*—Dr. Susan M. Hicks, Atlanta, Ga.; *Surgery*—Dr. Wm. A. Boise, Knoxville, Tenn.; *Op., Ot., and Laryngology*—Dr. Wm. Rufus King, Washington, D.C.; *Homœopathy Propagandism*—Dr. A. H. Schott, St. Louis, Mo.; *Obstetrics*—Dr. W. L. McCreary, Knoxville, Tenn.; *Gynecology*—Dr. E. J. Burch, Carthage, Mo.; *Clinical Medicine*—Dr. H. R. Stout, Jacksonville, Fla.; *Sanitary Science*—Dr. A. L. Smethers, Anderson, S. C.

Application for blanks for membership and all other information may be obtained by addressing Secretary, Dr. Lee Norman, 712 West Broadway, Louisville, Ky.

**The West Jersey Homœopathic Medical Society** held its summer meeting in the parlor of the West Jersey Homœopathic Hospital, West and Stephens' Streets, Camden, N. J., on Wednesday afternoon, August 20th.

The following program was prepared: "Glycosuria of Pregnancy," by Edward Clement, M.D.; "Defective Reaction," by H. B. Dean, M.D.; "The Action of Iodine on the Thyroid Gland," by Wallace McGeorge, M.D.

**An Important Communication.**—Are you a member of the State Society? If not, send in your application at once. The organization needs you, and you also need the benefits which association with the members can give you. Every homœopathic physician practicing in this State owes it to himself to become affiliated with this organization.

We have the biggest and best and most influential State organization in the country, and we can only maintain this position by continuing the good work of previous years.

To you who are members, let me urge you to become interested in your nearest neighbor who is not a member and endeavor to get him into line.

A membership blank will be found in this copy of the "Hahnemannian." Make good use of it by sending in your application at once. Do not delay, as the next State meeting will be held September 2, 3, 4, at Bedford Springs.

CHAS. A. LEY,  
Chairman of Membership Committee,  
First National Bank Building,  
Pittsburgh, Pa.

**The American Institute of Homœopathy** held its sixty-sixth annual meeting at Denver, Colorado, July 7, 1913. The number of physicians and officers in attendance was four hundred and nineteen, which is about up to the usual number of the past few years. As might be expected, the majority of physicians in attendance were from the West and Middle West.

Many matters of importance were transacted by the Institute and particular attention was devoted to the financial management of the Society. A committee was appointed to confer with the Regents of the American College of Surgeons to secure a representation of homœopathic surgeons on the Board of Regents. The committee appointed consists of Dr. James C. Wood, Cleveland; DeWitt G. Wilcox, Boston; James W. Ward, San Francisco; Walter Gray Crump, N. Y.; Herbert Dana

Schrenck, Brooklyn; Howard C. Chislett, Chicago; Gilbert FitzPatrick, Chicago.

Of great interest was the report of the committee headed by Dr. H. D. Schrenck, appointed five years ago for the purpose of inducing the American Medical Association to enter into an impartial investigation of the value of homœopathic methods of treatment of diseases. At the last meeting of the American Medical Association, Dr. Abraham Jacobi recommended that a committee be appointed to confer with the representatives of the homœopathic school for the purpose of such an investigation, and Dr. Schrenck reports that the establishment of such a committee is now assured.

The following officers were elected for the ensuing year: President, Dr. DeWitt G. Wilcox, Boston; first vice-president, Dr. Grant S. Peck, Denver; second vice-president, Dr. Anna D. Varner, Pittsburgh, Pa.; secretary, Dr. J. Richey Horner, Cleveland, Ohio; treasurer, Dr. T. Franklin Smith, New York; registrar, Dr. W. O. Forbes, Hot Springs, Ark.; censor, Dr. Walter E. Reily, Fulton, Mo.; trustees, Dr. W. B. Hinsdale, Ann Arbor, Mich.; Dr. James W. Ward, San Francisco, Cal.; Dr. John F. Sutherland, Boston, Mass.

Atlantic City was selected as the place for the next meeting and it is planned to hold the sessions in the Chalfonte Hotel.

**The International Homœopathic Council** held its meeting at Ghent in Belgium, August 8-9-10, 1913. This Council had its inception at the International Homœopathic Congress held in London in 1911. The objects of the Council are to promote—First, a general propaganda of homœopathy by lectures and literature and, Second, a closer bond of International Homœopathy.

The first executive meeting was held in Zurich, August 12, 1912, Dr. J. H. McClelland, Pittsburgh, presiding.

During the past year active work has been carried on in a number of foreign countries especially Sweden, Germany and Russia. The following extracts from the report of Dr. E. Petrie Hoyle, concerning his German lecture tour under the auspices of the International Homœopathic Council, will give you an idea of the kind of work that is being done.

"A start was made from London at 8.35 P. M., on February 10th, with a night crossing over to Flushing, arriving at Magdeburg, the town selected by our German colleagues for the first demonstration, on the evening of the 11th February, 1913.

Sanitätsrat Dr. Nissen, the Senior Homœopathic practitioner in that interesting old city, met me and made me heartily welcome. He had arranged that I should be present that evening as guest of the English Club of Magdeburg. The club includes English Speaking Germans (merchants, etc.), as well as English subjects.

One reason for mentioning this pleasant and instructive evening is that this English Club did the Council the honor of being present next evening at my address, almost to a man, and I think that many were impressed with the presentment of Homœopathy, some hearing of Homœopathy for the first time.

The presence of these members was one reason that my address was first given in English, almost in its entirety, followed afterwards by the forcible rendering of it into German by Dr. Nissen.

The hall proved to be hardly large enough, and many had to stand, whilst some went away unable to gain entrance.



At this and all other lectures there was given to each member of the audience a sheet containing Homœopathic statistics, prepared by the International Homœopathic Council from the most trustworthy sources, and rendered into German. At the close of the evening, Dr. Nissen handed the Envoy 120 marks, privately collected, for the Council's funds. The entrance was free, by invitation card.

At 8 A. M. next day, I left for Berlin, being met there by Dr. Honecamp, who had been delegated by the Beliner Homöopathisches Aertzte Verein, under whose auspices the Council here worked, to pilot me and after a survey of the facilities of the large Hall of the Lehrers Verein, with a capacity of over 1,200 seats, I was entertained as the guest of the Berlin colleagues, at their regular meeting which happened to fall that evening, being the one prior to that appointed for the Berlin address.

Many things were discussed that night, one of the most important to record being the report of Dr. Kroner, of Potsdam, of eleven cases of septic puerperal infection, all very serious, and all I think coming to him late in the course of the disease, some as late as the ninth day of fever, and every one cured by him, with **Pyrogenium** (about 10x I think was used). In many cases the good effect was remarkably prompt.

On the evening of the 14th, I addressed a very packed hall, very many **extra chairs** being crowded in and many people having to stand. They thought about 1,600 might be present. The address had been timed to correspond with the annual "benefit" for the Berlin Homœopathic Hospital, situated just outside the city, at Gross Licherfeld, because the city is so portioned out by the Government, to all the allopathic hospitals, that there is no Homœopathic Hospital allowed within the city, which is a most unfortunate handicap for our colleagues.

The body of the hall was for reserved seats at three marks, the sides and the galleries being slightly cheaper, the proceeds going towards the annual assets of the Hospital.

The Envoy addressed the audience for about twelve minutes only, as the percentage of English speaking people was small.

The remarks were by way of emphasis on the translation which was to follow, and which was here rendered by Dr. Kroner.

The slides, showing our great American Hospitals and also comparative statistics evoked great interest and surprise, even to our colleagues, as no one had any idea to what extent Homœopathy had spread in U. S. A., nor that we enjoyed any State support at all.

The kindness of the Berlin colleagues did not end with their hearty welcome. They made up a donation privately, of the sum of 200 marks, towards the Council's expenses. We trust that the undoubted interest shown at the time may be the starting point of a new campaign of propagandist activity.

Quite early the following morning I went to Wiesbaden where "the only" Dr. Kranz-Busch made us the recipient of his hearty hospitality, and on the following Monday pioneered me to Frankfurt, where I gave the "Official Address." I spoke first by way of emphasis for about twelve minutes (in English), the translated version being afterwards read by Dr. Kranz-Busch.

The hall contained very warm adherents of Homœopathy, but it was not quite full. Some spoke to me afterwards, in English, saying how surprised they had been with what there was to learn of America's progress.

# THE HAHNEMANNIAN MONTHLY NEWS AND ADVERTISER

A Medical Newspaper

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SEPTEMBER, 1913

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**Anatomy, Descriptive and Applied.** By Henry Gray, F.R.S., Fellow of the Royal College of Surgeons; lecturer on Anatomy at St. George's Hospital Medical School, London. New (American) edition, thoroughly revised and re-edited, with the ordinary terminology followed by the Basle Anatomical Nomenclature, by Edward Anthony Spitzka, M.D., Director of the Daniel Baugh Institute of Anatomy and Professor of General Anatomy in the Jefferson Medical College of Philadelphia. Imperial octavo, 1502 pages, with 1225 large and elaborate engravings. Cloth, \$6.00, net; leather, \$7.00, net. Lea & Febiger, Publishers, Philadelphia and New York, 1913.

"Gray's Anatomy" has for over fifty years been "the best known work in all medical literature." Measured by the number of students, physicians and surgeons who use it, and by the way in which they keep it and constantly refer to it, it is "incomparably the greatest text-book in medicine."

The announcement of a new edition of this great work is always a matter of exceptional interest and importance to the entire profession, and the appearance of this particular edition is especially significant because it ushers in the new era of teaching, marked by the raising and

standardizing of the requirements in almost all of the medical colleges of the United States. It is generally conceded that in the near future, anatomy will everywhere be taught according to the Basle Anatomical Nomenclature, and the B. N. A. terms have therefore been introduced in parentheses following the ordinary terminology, which is still in more general use, so that either or both may be used with facility.

The revision for this edition has been very thorough. Every line has been critically considered and the whole work has been brought abreast of the latest knowledge of anatomy and the most approved methods of presentation. A feature in which Gray has always been unique—the engraving of the names of the parts directly on the illustrations—is carefully preserved. The student is thus enabled at a glance to visualize the name of the part, its position, extent and relations, thus photographing in the memory knowledge otherwise painfully difficult to retain. Colors are abundantly used, and dissecting directions accompany the descriptions of the parts. A superb index comprising both terminologies in a single alphabet completes all the service which it is possible for a book to render. Its combination of unrivaled engravings and an incomparably clear text, reflecting the life-work of many of the world's masters of anatomy, and its peculiar quality of presentation which facilitates to the utmost the acquisition and retention of a sound knowledge of its subject, have maintained it in the premier position of all text-books on anatomy for over fifty years, and it was never stronger in attraction or farther in advance of its competitors than in this new edition.

**Minor and Operative Surgery, Including Bandaging.** By Henry R. Wharton, M.D., Professor of Clinical Surgery in the Woman's Medical College, Philadelphia. New (eighth) edition, enlarged and thoroughly revised. 12mo, 700 pages, with 570 illustrations. Cloth, \$3.00, net. Lea & Febiger, Philadelphia and New York, 1913.

When a medical work has reached its eighth edition it may be pronounced a conspicuous success. Only a long continued and steady demand could make possible such a record, and this in turn must be based on intrinsic value. Wharton's Minor and Operative Surgery is a book of great utility and convenience. Its text is clear, and, wherever possible, is helped by its excellent illustrations, of which there are nearly six hundred, showing in many cases the steps of the various procedures. Many of them are photographs, and in the section on bandaging they are especially abundant. This new edition gives evidence of thorough and careful revision. All matter which has become obsolete has been omitted, and a large amount of new material has been added.

**A Manual of Otology.** By Gorham Bacon, A.M., M.D., Professor of Otology in the College of Physicians and Surgeons, Columbia University, New York. New (6th) edition, thoroughly revised. 12mo, 536 pages, with 164 engravings and 12 plates. Cloth, \$2.25, net. Lea and Febiger, Philadelphia and New York, 1913.

The frequency with which new editions of this Manual are called for indicates a widespread popularity among practitioners and specialists, and shows that it fills admirably the important function of a students' text-book. Its many sterling qualities have resulted in its being "the standard manual of otology in the English language and a model for



all works of a similar nature." It has never been approached in its excellent methods of presentation, and it stands practically without a rival in its special field. An examination of this new edition shows that it reflects the subject in its latest aspect. Many sections have been wholly rewritten and considerably enlarged. Emphasis has been laid on the most modern methods of diagnosis and treatment. The excellent series of illustrations has been increased by many new ones, which have been inserted wherever they could be of value in helping to an understanding of the problems under discussion.

**The Surgical Clinics of John B. Murphy, M.D.,** at Mercy Hospital, Chicago. Volume II. Number IV. (August, 1913.) Octavo of 206 pages, 49 illustrations. Philadelphia and London: W. B. Saunders Company, 1913. Published Bi-Monthly. Price per year—Paper, \$8.00; Cloth, \$12.00.

This volume of "Murphy's Clinics" deals largely with surgery of the bones. Of especial interest to medical men is a very excellent contribution by Dr. Kreusher on vaccination and serum therapy. The volume also contains a series of ten skiagrams illustrating the blood supply in and around the joints.

**Mechanical Treatment of Abdominal Hernia.** By William Burton DeGarmo, M.D., Professor of Special Surgery New York Post-Graduate Medical School and Hospital; Fellow New York Academy of Medicine; Member American Medical Association, etc. Philadelphia and London, J. B. Lippincott Company. The price of this book is \$1.50.

This little work is intended as a guide in the selection and fitting of trusses and especially as an aid to those who have no interest in the surgical side of the subject.

When we consider the number of trusses that are fitted both by physicians and by laymen who have little actual knowledge of the subject, it is evident that a work of this kind will find a large sphere of usefulness both among physicians and truss fitters in general.

**The Narcotic Drug Diseases and Allied Ailments,** Pathology, Pathogenesis and Treatment. By George E. Pettey, M.D., Member Memphis and Shelby County Medical Society, Tennessee State Medical Association, etc. Illustrated. Philadelphia, F. A. Davis Company, Publishers. Price, \$5.00.

The author of this volume advances the proposition that narcotic drug addiction is a disease, a toxemia of combined drug and intestinal origin. The essential principle involved in this treatment is elimination. In order to make the volume of greater value to the general practitioner, much space is devoted to the treatment of acute ailments occurring in alcoholic and narcotic habitues and the withdrawal of narcotics after prolonged use after acute ailments. The treatment of delirium tremens and sobering up of acute alcoholism, which subject is an important one and one that the family practitioner as a rule has but a vague knowledge and the volume before us will serve to furnish just such information as he is likely to need on the subject.

**Diseases of the Nose, Throat and Ear.**—By Francis R. Packard, M.D., Philadelphia. Published by J. B. Lippincott Company, Philadelphia. Second Edition. Price, \$3.00.

The need for a second edition of this comprehensive little book indicates that strides have been made in the recent progress of Rhinology and Laryngology. The sections dealing with diseases of the tonsils and adenoids has been entirely rewritten and fully described—the technique in direct tracheobronchoscopy and in accessory sinus operations has been incorporated. Dr. Packard's book is based on many years of experience in the Philadelphia Polyclinic Hospital, and not being burdened with too many theories is a reliable work for graduate and undergraduate students of rhinology.

**Progressive Medicine.** A Quarterly Digest of Advances, Discoveries and Improvements in the Medical and Surgical Sciences. Edited by Hobart Amory Hare, M.D., Professor of Therapeutics and Materia Medica in the Jefferson Medical College, Philadelphia, assisted by Leighton F. Appleman, M.D., Instructor in Therapeutics, Jefferson Medical College, Philadelphia. September 1, 1913, Philadelphia and New York, Lea & Febiger. Six Dollars per annum.

This issue of "Progressive Medicine," containing as it does, a review of the literature of diseases of the heart, lungs, blood vessels, dermatology, obstetrics and diseases of the nervous system, naturally contains much that is of interest to the general medical practitioner. Probably the most striking series of articles are those by Ewart on the value of artificial pneumothorax in the treatment of incipient advanced pulmonary tuberculosis. The writer seems to feel that this method of treatment is the most important therapeutic measure at our command in the management of this widespread disease.

**A Practical Treatise on Fractures and Dislocations.** By L. A. Stimson, B.A., M.D., LL.D., Professor of Surgery, Cornell University Medical College, New York. Seventh edition enlarged and revised. Four hundred and fifty illustrations, thirty-nine plates in monotone. Lea & Febiger, New York and Philadelphia, 1912.

This classical work which has proved so popular with the medical profession now appears in its seventh edition. The author follows the same general style as in the previous editions. The principal additions that have been made are in connection with the subject of treatment especially in that of old dislocations and in respect of the operative treatment of recent fractures. More than one hundred illustrations have been added. Stimson's work is probably the most complete and illustrative work on the subject of fractures and dislocation before the American profession.

#### PENNSYLVANIA STATE NOTES.

**The Regular Meeting of the Hahnemann Medical Society of Berks County** was held at the Homœopathic Hospital on September 4, 1913.

The meeting was called to order by the President, Dr. C. B. Jennings at 9 P. M. The members present were: Dr. C. B. Jennings, Dr. Theodore Pachali, Dr. S. L. Driebilbis, Dr. Leon Driebilbis, Dr. C. R. Curry, Dr. William Haman, Dr. C. R. Haman, Dr. F. F. Massey, Dr. W. F. Marks, Dr. George I. Keim, Dr. D. L. Kline, Dr. F. H. Lawrence, secretary.

The following officers were elected: Dr. C. B. Jennings, president,

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## The Hahnemannian Monthly

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OFFICIAL JOURNAL *of the*  
HOMOEOPATHIC STATE  
MEDICAL SOCIETY OF  
PENNSYLVANIA : : : : :

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*Published at 1807 Chestnut Street : Philadelphia*



for year 1913-1914. Frank H. Lawrence, secretary and treasurer. Wm. A. Haman, S. L. Driebilbis and Paul Gerhardt were elected as censors. Dr. F. F. Massey extended an invitation to entertain the Society at Walter's Park. Referred to committee on entertainment who will, no doubt, report favorably.

As Dr. A. S. McDowell is at the present confined in the Homœopathic Hospital with typhoid fever, he being an active member of the Society, it was moved and seconded that the Society send a remembrance of a bouquet of flowers, with the best wishes for a speedy recovery. The paper of the evening was read by Dr. Frank H. Lawrence. The title of the paper was: "Prevention and Treatment of Typhoid Fever." This paper was followed by a discussion. The president appointed Dr. F. F. Massey essayist for the month of October.

Frank H. Lawrence, M.D.

**Fiftieth Annual Session of the Homœopathic Medical Society of the State of Pennsylvania** met at Bedford Springs, Pa., September 2, 3, 4, 1913. The session was called to order on Tuesday morning, September 2nd, at 10.30 by the President, Dr. H. I. Nicholson, of Pittsburgh. The Rev. J. Alfred Eyler, Bedford, offered a prayer. Dr. E. H. Pond, of Pittsburgh, then read the report of the secretary, setting forth the fact that the transactions had been published and the program arranged in accordance with the rules of the Society.

Dr. Ella D. Goff presented the treasurer's report showing a substantial balance in the treasury. Then followed the reports of the various standing committees. (These reports will be published in a later issue of the "Hahnemannian Monthly.")

Second business session was called to order Wednesday morning, at 10.15 by President Nicholson. The Board of Censors reported favorably on the names of five applicants and they were unanimously elected to membership in the Society.

On motion of Dr. H. T. Schmitz, the Society voted the sum of fifty dollars to the International Propaganda Committee of the American Institute of Homœopathy.

Dr. H. D. Elliott, of Philadelphia, presented a communication regarding the neglected condition of the grave of Dr. Pemberton Dudley, former president of the Society. On motion of Dr. Dinsmore, the sum of fifty dollars was donated by the Society as a part of the fund to erect a suitable memorial to Dr. Dudley at 11 A. M.

The nomination of officers for the ensuing year was then taken up, the following nominations being offered: President, Dr. Leon T. Ashcraft, of Philadelphia; first vice-president, Dr. J. M. Heimbach, of Kane; second vice-president, Dr. H. M. Gay, of Philadelphia; secretary, Dr. I. D. Metzgar, Tyrone, Pa.; treasurer, Dr. Ella D. Goff, Pittsburgh, Pa.; Board of Censors, Dr. Edward Krusen, of Norristown; necrologist, Dr. William F. Baker, Philadelphia; associated editor, "Hahnemannian Monthly," Dr. Gilbert J. Palen, Philadelphia.

There were three nominations for the Board of Trustees: Dr. D. P. Maddux, of Chester; Dr. H. B. Bryson, of Pittsburgh; and Dr. J. R. Schwartz, of Harrisburg. There being no further nominations, nominations were closed with but one candidate for each office.

The third business session was called to order by Dr. Pond, on Thursday morning, September 4th.

The first order of business was the election of officers; there being but one candidate for each office, motion was made and carried that the secretary be instructed to cast a ballot electing those nominated the previous morning.

The President, Dr. Nicholson, declared those gentlemen elected as officers for the ensuing year.

A committee was appointed to consider the amendment of Article Seven, Section One of the By-Laws, reported in favor of changing the word "Five" to the word "Two" as provided for in the amendment offered by the Society in 1912.

The report of the Committee provided that every new member pay two dollars the first year and three dollars every subsequent year. This does away with the initial payment of five dollars on becoming a member of the Society. The report of the committee was accepted and the amendment carried. Dr. Pond made a motion that a vote of thanks be given to President Nicholson for his efficient work as an officer of the Society. The motion was seconded and carried. Dr. Heimbach then made a motion thanking Dr. Pond for his efficient and faithful work as secretary of the Society for five years. The motion was seconded and carried.

The meeting adjourned at 12.05 P. M. The scientific program contained many interesting papers covering the entire field of medical science and this was received and discussed with considerable interest by the Society. The social features consisted of a musical entertainment in which the members participated on Tuesday evening, and on Wednesday evening in the form of a banquet, Dr. W. W. Speakman acting as toastmaster on the latter occasion. One hundred and fifty members and guests were present at the banquet which was a very successful and enjoyable affair. It was quite a comparatively small attendance but considering the oppressive weather a very successful one and was most profitable and interesting to those who had an opportunity of attending.

**Hahnemann Medical College of Philadelphia** will open on Monday evening, September 22nd. The opening address will be delivered by Professor John E. James, Jr.

**Personals.**—John J. Tuller, M.D., desires to announce that on September 20, 1913, his office will be removed to 2108 Walnut Street, Philadelphia, Pa.

L. Willard Reading, M.D., Philadelphia, Pa., announces the opening of an office at 1825 Chestnut Street, Philadelphia. Electric and Spinal Therapy. Office: 1825 Chestnut Street. Hours: 9 to 11.30 A. M., 5 to 6 P. M. Bell Telephone, Locust 534. Residence: 6381 Overbrook Avenue. Hours: Until 8.30 A. M.; 7 to 8 P. M. Bell Telephone, Overbrook 3633-D.

#### Important Communication.

Editor "Hahnemannian Monthly":

Dear Doctor:

Will you kindly publish in your journal the following communication, the import of which is of interest to the medical profession?

During June of the year 1912, an applicant for licensure to prac-

tice medicine in Pennsylvania failed at the State examination and was told by the legislative committee of a County Medical Society, that if he entered upon the practice of medicine before taking the next State examination, he would not be molested by them nor by their County Medical Society, and probably not by the Bureau of Medical Education and Licensure.

At a later period a practitioner from another State was informed that she could begin and carry on the practice of medicine during the time she was waiting to take the State examination. In both instances the advice was contrary to law.

The recent amendments to the medical law make it the duty of the Bureau of Medical Education and Licensure to enforce the law; and the Bureau desires to serve notice that it is illegal for any one to begin to practice while waiting for the State examination or before obtaining a license from the Bureau, and that such violations of our medical law will be prosecuted and the offenders will be penalized in accordance with the provisions of the Acts of Assembly regulating the practice of medicine and surgery in the State of Pennsylvania.

Very respectfully,

Nathan C. Schaeffer,

Secretary, Bureau Medical Education & Licensure.

August 5, 1913.

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**Gold Medal for Mellin's Food.**—At the Seventeenth International Congress of Medicine, which convened in London, during August, Mellin's Food received the Gold Medal, which is the highest possible award in any class. This was the greatest congress of medical men the world has ever known; some of the most distinguished members of the medical profession from the United States and many other countries were in attendance, and for these reasons, and also because there were a large number of exhibitors present among whom rivalry for the awards was most keen, the Mellin's Food Company have reason to be proud of their product.

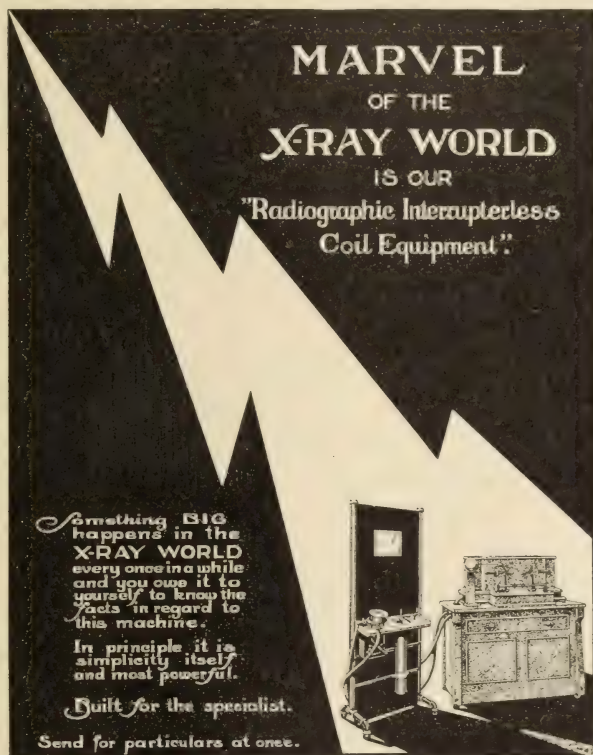
**Chronic Catarrhal Diseases.**—Chronic catarrh never fails to indicate general constitutional debility. Local treatment is always desirable but for permanent results efforts must be directed toward promoting general functional activity throughout the body, and a general increase of systemic vitality. The notable capacity of Gray's Glycerine Tonic Comp. in this direction readily accounts for the gratifying results that can be accomplished through its use in the treatment of all chronic catarrhal affections, but especially those of the gastro-intestinal canal and respiratory tract. The particularly gratifying features in the results accomplished by Gray's Glycerine Tonic Comp. are their substantial and permanent character. This is naturally to be expected since they are brought about through restoring the physiologic balance of the whole organism.

**Cardiac Stress—Its Safe and Effective Relief.**—Occasions frequently arise when the practitioner must support the heart in order that brief periods of great stress or over-taxation may not result in permanent disability. For instance, during febrile attacks, or at moments of great mental shock, the heart's action is often temporarily embarrassed. At



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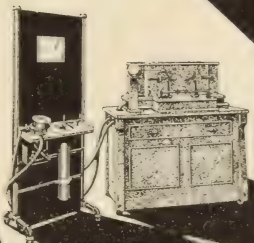
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such times a dependable cardiac tonic is needed, and for a good many years Cactina Pillets have been employed by thousands of physicians with the utmost satisfaction.

This carefully prepared preparation of *cereus grandiflorus* has been found to give the tired heart the exact support and bracing effect required to enable it to meet safely and without discomfort sudden and unexpected drafts on its functional capacity. In the presence of cardiac palpitation, irregular action, tachycardia or the various other symptoms pointing to fatigue and functional weakness of the heart, Cactina Pillets afford prompt relief and rapidly remove the patient's apprehension and fear. Indeed, it is not unusual for a patient to run the whole gamut of the customary heart remedies without the slightest benefit until he is placed on Cactina Pillets. There can be no question that this remedy is especially effective in the cardiac neuroses and it has the great advantage that it can be used without a single fear of any idiosyncratic or untoward effect, or cumulative action, no matter how long or continuously it may be administered.

The practitioner who familiarizes himself with the virtues of Cactina will be gratified to learn the extent to which he can rely on this valuable remedy as a heart regulator and support. And the more he uses it the more he will see that Cactina is not a spur or a goad—but a thoroughly dependable tonic and prop.

**Malnutrition.**—Malnutrition as a cause of infant mortality, occurs in breast fed as well as in artificially fed infants, and whether this common functional complaint is called Marasmus, Inanition, Infantile Atrophy or Athrepsia, common consent points to arrested digestive growth. Growth being the principal function of infancy, any disturbance of it constitutes a serious condition. It is found that the absence of gastric activity is relatively constant in children suffering from Malnutrition.

Bar considers Malnutrition is due to lack of ferments in the infant's stomach.

Malnutrition requires a food in which in addition to the milk, certain components should be present in order to compensate for the loss that is taken place as a result of disease; the fat should be restricted in the treatment, and its place must be taken by carbohydrates,—the fat content only being raised with the increased weight of the baby.

The success of mixed carbohydrates in difficult feeding cases warrant their continuance. Cow's milk is an alien substance, and acts as a poison unless ferments are present to modify it.

The intelligent use of Benger's Food at the hands of the physician or trained nurse, is the only precise method of presenting, at once, a food in which the milk is modified by definite ferments, and the carbohydrates are converted into soluble malt sugars; the fat not being affected, milk sugar may be added.

Anxiety in the feeding of these difficult conditions, which come under the heading of Malnutrition, is at once removed, where Benger's Food is used at an early stage.

According to one medical authority: "In cases of Marasmus, and indigestion, Benger's Food is, indeed, perhaps the most universally applicable of all foods."

The Benger's Food Company, New York, will be glad to send formulae, samples, etc. Mention this paper when writing.

# THE HAHNEMANNIAN MONTHLY NEWS AND ADVERTISER

A Medical Newspaper

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OCTOBER, 1913

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**Elementary Dermatology, An Epitome of the More Common Skin Diseases for Students and Practitioners.** Alphabetically arranged. By Ralph Bernstein, M.D., Philadelphia, Pa., Clinical Professor of Dermatology, Hahnemann Medical College, Philadelphia; Clinical Chief, Skin Section, Hahnemann Hospital Dispensary, Philadelphia; Consulting Dermatologist, Hahnemann Hospital, Philadelphia, etc., etc. Fully illustrated. Boericke and Runyon, New York and Philadelphia. Price, \$3.00.

In this volume the author has endeavored to present in a clear and concise manner such practical information relating to diseases of the skin as will enable the student and medical practitioner to correctly diagnose and treat the dermatological affections that come under his attention. The text is divided into twenty chapters, some of the most important of which deal with "Dermatologic Reasoning"; "Routine Examinations"; "Dermatologic Symptomatology"; "Classification of Skin Diseases"; "External Cutaneous Therapy"; "List of Dermatologic Remedies"; "Bacteriological Dermatology." From the standpoint of diagnosis,



Dr. Bernstein has given us a schema whereby the student and practitioner can work out his diagnosis from the location and character of the lesions and their duration. The work is particularly to be commended because of the attention given to the therapeutics of skin diseases. The reasons for the selection of various external applications are carefully gone over and the formulæ for such applications are given. The author confines himself to those that have been demonstrated by clinical experience to be of exceptional value. In addition, it contains a complete summary of the homœopathic therapeutics of skin diseases arranged according to lesions, locations, sensations and motility with a complete repertory of over one hundred and twenty-five remedies. The work is profusely illustrated, is printed in large type on paper of exceptional quality and both the author and the publishers are to be congratulated upon the production of a work that from every standpoint is a credit to themselves and to the homœopathic profession.

**Oxford Medical Publications: Headache:** Its Varieties, their Nature, Recognition and Treatment. A Theoretical and Practical Treatise for Students and Practitioners.—By Dr. Siegmund Auerbach, Chief of the Polyclinic for Nervous Diseases in Frankfurt, A. M. Translated by Ernest Playfair, M.B., M. R. C. P. London, Henry Frowde and Hodder and Stoughton, Oxford University Press, Warwick Square, E. C. American Branch, 35 West 32nd Street, New York City. Price, \$1.50.

Every physician recognizes the need of a clear exposition of the differential diagnosis of the various varieties of headache, as such diagnosis is essential to rational treatment. Most of the larger text-books deal chiefly with serious disorders, while the minor ailments are neglected. This little monograph in which the subject is covered concisely and yet completely should find a place in the library of every medical practitioner.

**Syphilis and the Nervous System,** for Practitioners, Neurologists and Syphilologists.—By Dr. Max Nonne, Chief of the Nervous Department in the General Hospital, Hamburg, Eppendorf. Authorized translation from the second revised and enlarged German edition, by Charles R. Ball, M.D., Chief of the Nervous and Mental Departments, St. Paul Free Dispensary, etc. Ninety-eight illustrations in text. Price, \$4.00. J. B. Lippincott Company, Philadelphia, and London.

This work is a translation of Dr. Nonne's well known writings that have attained such high popularity in Germany. Since the discovery of the micro-organism of syphilis by Schaudinn, and the development of the Wassermann test, the subject of syphilis of the nervous system has undergone a complete reconstruction; and the symptomatology and prognosis of syphilitic affections of the nervous system have radically changed. While a work of importance to the specialist, it is also a volume that should attract the attention of every progressive general practitioner. It is the general practitioner who first comes in contact with these cases in the majority of instances and the early recognition of the nature of such cases would be productive of much good results both for patient and physician.

**Blood-Pressure**, from the Clinical Standpoint.—By Francis Ashley Faught, M.D., of the Medico-Chirurgical College, Philadelphia. Octavo of 281 pages, illustrated. Philadelphia and London: W. B. Saunders Company, 1913. Price, \$3.00 net.

During the past few years great interest has been attracted to the clinical importance of high and low blood pressure in diagnosis and in prognosis. In this volume the author has endeavored to present in an easily accessible form the pith of medical literature bearing on blood pressure studies in their relation to medicine. Considerable space has also been devoted to a discussion of the circulation and its relation to blood pressure, together with the various methods employed in sphygmomanometry. Dr. Faught is a well recognized authority on this subject and his book contains much that will prove valuable and interesting to all medical practitioners.

**Diseases of the Eye**.—By George E. deSchweinitz, M.D., Professor of Ophthalmology in the University of Pennsylvania. Seventh Edition, Thoroughly Revised. Octavo of 979 pages. 360 text illustrations, and seven lithographic plates. Philadelphia and London: W. B. Saunders Company, 1913. Cloth, \$5.00 net; Half Morocco, \$6.00 net.

A detailed review of this well known and authoritative work now in its seventh edition, is unnecessary. It is sufficient to say that the author has followed out the general plan of the previous editions and has incorporated such information as has been necessary to bring the work strictly up to date. Among the additions we note a discussion of vaccine therapy in relation to eye diseases; the use of salvarsan in ocular disorders; Reese's muscle resection; operation and Siegrist's method of local anaesthesia.

**Gonorrhea in Women**. Its Pathology, Symptomatology, Diagnosis and Treatment: Together with a review of the rare varieties of the disease which occur in men, women and children. By Charles C. Norris, M.D., Instructor in Gynecology, at the University of Pennsylvania. Octavo of 521 pages, illustrated. Philadelphia and London: W. B. Saunders Company, 1913. Cloth, \$6.00 net; Half Morocco, \$7.50 net.

This monograph of about five hundred pages is a very thorough and complete summary of our present knowledge of the subject of gonorrhea in women. Until recently, this disease was regarded as a purely local one and it is only lately that the etiology of a large percentage of pelvic inflammation was traced to the gonococcus. In the present work, Dr. Norris takes up the pathologic changes produced by the gonococcus in the female. The prophylaxis of gonorrhea and the local and general treatment of the various manifestations of gonorrheal infection. The work is well illustrated and constitutes a complete and authoritative review of our present knowledge of this important subject.

**Collected Papers by the Staff of St. Mary's Hospital (Mayo Clinic) for 1912**. Octavo of 842 Pages, 219 Illustrations. Philadelphia and London: W. B. Saunders Company, 1913. Cloth, \$5.50 net.

The publication of the papers by the staff of the Mayo Clinic has

become an event looked forward to with interest each year by the medical profession. The present volume contains about eight hundred pages. The subjects are presented under seven headings—the alimentary canal; hernia; uro-genital organs; ductless glands; head, neck; spinal column and extremities; technique and general papers. The articles dealing with the subject of surgery of the spleen and of goitre offer much that is new and valuable. Dr. Gray's paper—an analysis of thirteen thousand cases examined for errors of refraction, is valuable because of the deductions drawn from such an amount of material. Smithies' article on the Tryptophan test for gastric cancer is also very instructive.

**The Principles and Practice of Gynecology. For Students and Practitioners.** By E. C. Dudley, A.M., M.D., Professor of Gynecology in the Northwestern University Medical School, Chicago. Sixth Edition, thoroughly revised. Octavo, 795 pages, with 439 illustrations, of which many are in colors, and 24 full page plates. Cloth, \$5.00 net. Lea & Febiger, Publishers, Philadelphia and New York, 1913.

"Dudley" is unquestionably one of the strongest books on gynecology in the English language. Ever since its original publication, fifteen years ago, it has occupied the foremost place among American works on this subject, and the appearance of this new edition serves to strengthen it in this leading position. Its splendid record is evidenced in the complete originality of its elaborate engravings and plates, a feature possible in very few publications. Each one is designed to illustrate some special point in the text, and numerous series of drawings explain operative procedures as they take place, step by step. In its pictorial department the work stands unrivaled. The arrangement of the book is another excellent feature. The subjects are presented in pathological and etiological sequence, so that the reader will have constantly before him the physiological and pathological unity of the reproductive system, and will see the correlation of like morbid processes to each other. The text shows that it has had thorough revision throughout. Several chapters have been entirely rewritten, and many new illustrations added. In its latest issue this standard work is well equipped for a new period of usefulness as the recognized authority.

**Obstetrics. A Manual for Students and Practitioners.** By W. P. Manton, M.D., Professor of Obstetrics and Clinical Gynecology, Detroit College of Medicine, Detroit, Mich. Second edition, revised and enlarged; including selected list of State Board Examination Questions. 12mo, 292 pages, with 97 engravings. Cloth, \$1.00 net. Lea & Febiger, Publishers, Philadelphia and New York, 1913.

This little volume fills admirably the two-fold purpose for which it was created, namely, a convenient manual by which the physician can quickly refresh his memory, and an excellent means by which the student can review his course on obstetrics in preparing for examination. The questions appended to each chapter will be found a strong mental stimulus. The revision for this new edition has been so thorough that it has amounted virtually to a rewriting, so that the book is really a new one. It is exceptionally well illustrated, and is typographically all that could be desired. Its large circulation is apparent in the unusual value which the purchaser receives.



# *American Institute of Homoeopathy*

***Will Meet at Atlantic City in June, 1914***

THE sessions of the Institute will not be held upon a pier, as was the case in 1906. One of the great hotels will accommodate us, and all meetings will be held under one roof.

June, 1914, should see the greatest attendance of members in the history of the Institute. Now is the time for homœopathic physicians not members of the Institute to send in their applications for membership so as to have the full benefit at this meeting. Write to the Secretary, 659 Rose Building, Cleveland, Ohio.

## PROOF

The Value of an Advertising Medium is readily ascertained by the results.

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If the most expert Advertisers persistently spend money in the HAHNEMANNIAN, their action proves its value.

**A Treatise on the Diseases of Women. For Students and Practitioners.**

By Palmer Findley, B.S., M.D., Professor of Gynecology, College of Medicine, State University of Nebraska; Gynecologist to the Clarkson Memorial Hospital and Douglas County Hospital; Fellow of the American Gynecological Society; Fellow of the American Association of Obstetricians and Gynecologists; Fellow of the Chicago Gynecological Society. Octavo, 954 pages, illustrated with 632 engravings in the text and 38 plates in colors and monochrome. Cloth, \$6.00 net. Lea & Febiger, Philadelphia and New York, 1913.

This new work offers a complete exposition of the subject of diseases of women, and brings out many points of view not generally emphasized in books on gynecology. A very important feature is the full discussion given to conservative methods of treatment, such as douches, baths, exercise, massage, diet, dress and tampons, which rarely receive the consideration which their importance merits, either in books or in actual practice. Separate chapters are devoted to Non-operative Methods of Treatment, Hygiene and Dress, Preparation of Patient for Operation, Preparation of Operating Room, Field of Operation and Surgical Utensils, Choice of Anesthetics, Diet, Post-operative Complications and Care of Patients after Operation. Diagnosis has been placed on an anatomical basis, for it is pre-eminently true of diseases of women that the making of a diagnosis is in large part the recognition of the morbid anatomy. Another valuable feature is the presentation of certain subjects which may be considered as on the borderline between gynecology and obstetrics, for the separation of these two subjects is an illogical one. The book is very rich in its pictorial department, for in the text there are 632 engravings, besides 38 plates, many of which are colored. They have been inserted wherever it was possible to make clearer the point under discussion.

**The Psycho-Neuroses and Their Treatment by Psychotherapy.**

By Professor J. Dejerine, Professor of the Clinic for Nervous Diseases of the Faculty of Medicine of the University of Paris, and Dr. E. Gauckler, Ancien Interne of the Hospitals of Paris. Authorized translation by Smith Ely Jelliffe, M.D., Ph.D., Adjunct Professor of Diseases of the Mind and Nervous System, Post-Graduate Medical School and Hospital; Visiting Neurologist, City Hospital, New York. J. B. Lippincott & Company, Philadelphia and London. Price, \$4.00.

During the past few years a number of works have appeared on the subject of psychotherapeutics. The demand for works of this character has come about largely because of the admitted failure of traditional medical methods in dealing with functional nervous diseases and because of the relatively brilliant results that were obtained by the pioneers in Psychotherapy. The present volume is a translation of Dejerine's well-known French work on this subject. Professor Dejerine has laid special emphasis upon the emotional factors present in the disorders of nervous origin. He believes that it is especially necessary to appeal to the feelings of the neurotic individual and that rational ideas alone produce no effect unless accompanied by an emotional appeal which makes them acceptable to consciousness and thus bring about conviction. The scope of the work includes consideration of the etiology and manifestations of functional nervous diseases of the psycho-therapeutic steps to be employed in their cure.

**An Introduction to the Study of Infection and Immunity. Including Serum Therapy, Vaccine Therapy, Chemotherapy and Serum Diagnosis.** By Charles E. Simon, M.D., Professor of Clinical Pathology and Experimental Medicine, College of Physicians and Surgeons, Baltimore. New (2d) Edition, thoroughly revised. Octavo, 325 pages; illustrated. Cloth, \$3.25, net. Lea & Febiger, Publishers, Philadelphia and New York, 1913.

The exhaustion of the entire first edition of this work in less than a year shows beyond question that it is a book of great value and utility to the practising physician. On glancing over the table of contents it is obvious that each one of the chapters is worth many times the price of the volume, because of the fund of new and important information contained and the new ideas which are set forth. The marvellous advances of modern experimental medicine have placed within the reach of the profession new methods of diagnosis, therapeutics and prophylaxis, more exact and effective than anything hitherto known to medical science, and the physician who would possess this new knowledge and master its many practical applications will find them presented in this work clearly and succinctly, and in an easy and graceful style. The most notable achievements of the past year have been embodied. These include sections on auto- and normal serum therapy, on the chemotherapy of pneumococcus infections and of cancer, and on the serum diagnosis of pregnancy (Abderhalden's Test). The entire text has likewise been given a careful revision.

#### PENNSYLVANIA STATE NOTES.

**The Homœopathic Medical Society of the County of Philadelphia,** held its regular monthly meeting at Hahnemann College, Thursday evening, September 11, 1913, at 8.30 o'clock. The President, Dr. Herbert P. Leopold read his annual address, outlining the work for the coming year. The meeting was well attended, and a very enjoyable time was had by those present.

Wm. M. Sylvis, M.D., Secy.

**The Philadelphia Society for Clinical Research** held its regular monthly meeting at the Philadelphia Athletic Club, on Thursday, September 18th. Many interesting topics were discussed at this meeting, after which the nomination of officers took place for the ensuing year. The members then participated in a ball game, after which supper was served to those present. The meeting proved to be a very enjoyable one.

Percy A. Tindall, M.D., Secy.

**The Germantown Homœopathic Medical Society** held its regular monthly meeting at the "Majestic," Broad and Girard Avenue, on Monday, the Fifteenth of September, 1913, at 9 P. M. A very interesting paper on "Nasal Polyp," was read by Dr. George J. Alexander, after which a hearty discussion took place. The Censors reported favorably the name of Dr. Hayes Brown. Great interest was shown at this meeting by a large number of members present.

Landreth W. Thompson, M.D., Secy.

**The Homœopathic Medical Society of the 23rd Ward of Philadelphia** held its regular monthly meeting at the Hotel "Phoenix," Willow Grove, Pa., on Wednesday, September 20th, 1913. A well prepared paper was presented by Dr. W. L. Frank. Keen interest was shown at this meeting by a large number present.

John D. Boileau, M.D., Secy.



**The Women's Homœopathic Medical Association of Pittsburgh, Pa.,** held its regular monthly meeting at the office of Dr. Anna Johnston, 5016 Liberty Avenue, Pittsburgh, on Thursday, October 2, 1913, at 8 P. M. Many interesting topics were discussed at this meeting and work outlined for the ensuing year. There was a large attendance of members and an enjoyable time was had by those present.

Lydia B. Pierce, M.D., Secy.

**The West Jersey Homœopathic Medical Society** held its Summer Meeting in the parlor of the West Jersey Homœopathic Hospital, West and Stevens Streets, Camden, N. J., on Wednesday afternoon, August 20, 1913, at 1.30 o'clock. The scientific program consisted of the following: "Glycosuria of Pregnancy," Edgar Clement, M.D.; "Defective Reaction," H. B. Dean, M.D.; "The Action of Iodine on the Thyroid Glands," Wallace McGeorge, M.D. The discussion was opened by Dr. McGeorge, and proved to be an interesting one.

T. E. Parker, M.D., Secy.

**The Hahnemann Medical College of Philadelphia** held its opening session of 1913-1914 on Monday evening, September 22nd, at 8.30 o'clock, in Lecture Room No. 1. The Rev. Floyd W. Tomkins pronounced the invocation and gave a few words of welcome from the Trustees, after which Prof. John E. James, Jr., made a short address, which was followed by remarks made by the Dean, Dr. Wm. B. Van Lennep. It is highly gratifying to the Alumni and friends of the college to know that the student body has been showing a healthy increase, and that the Freshmen's Class this year is almost double last year's.

**The Medical Department of Hahnemann Medical College and Hospital** held a meeting at 1437 Spruce Street, Philadelphia, on Wednesday, September 17th, at 9 P. M. Work for the coming year and many important business matters were taken up at this meeting, which was well attended.

**The Medical Club of the 23rd Ward** held its annual Summer Outing on September 15, 1913, which consisted of a trip to Reading, Pa. Many members left Philadelphia to enjoy the day's outing which was pleasantly spent, and which proved to be an enjoyable affair.

**Personals.**—Mr. and Mrs. Clifford Holcombe Durant announce the marriage of their sister, Miss Mary Babbitt Blair to Doctor Marvin Clark Johnson, on Wednesday, the twenty-fourth of September, One thousand nine hundred and thirteen, at Hartford, Connecticut. At Home, Two hundred, Susquehanna Avenue, West Pittston, Pennsylvania.

Doctor John J. Tuller announces the opening of his office, 2108 Walnut Street, Philadelphia, Pa.

Doctor Harry H. Lewis announces the opening of his office, 1031 Centre Street, Ashland, Pa.

Doctor L. Willard Reading announces the opening of his office 1825 Chestnut Street, Philadelphia, Pa. Electro and Spinal Therapy.

**The Therapeutic Gazette—9-15-13.**—Weak or Flat-Foot Ailments are caused by a lack of strength of the muscles and ligaments that support and maintain the bony arches of the foot.

The attendant pains are caused by stretching of and pressure on the NERVES of the muscles. As long as the bony arches are fallen or depressed, the nerves will continue to be stretched and pressed upon. The pain will not only persist, but will be increased by the added irritation of blood congestion and stagnation, as a result of the continued displacement of the bones, muscles, ligaments and nerves.

The inner and outer foot arches do not always fall evenly, therefore, the Arch Lift must be capable of supporting either arch independently or both in combination, or be deficient in certain cases.

To firmly, yet gently, raise and support all the foot structures will reduce the pain and afford the best help toward final relief, but a CURE cannot be effected until the bony arches are restored to their normal position and the strength of the muscles and ligaments regained.

The elevation of the bony arches must be complete and CAN be obtained with "TRUFIT" Arch Lifts in a slow, gradual manner, with comfort and continued use of the feet. Too much pressure or too sudden uplift is not only irritating, but may be damaging. "TRUFITS" are the only Arch Lifts which permit the accurate adjustment necessary.

**The Secretary of the Treasury and the Public Health Service.**—The annual report Mr. McVeagh has just submitted to Congress clearly demonstrates that the opinion of some to the effect that the Secretary of the Treasury takes no active interest in public health work—indeed, that he is inimical to present conditions—is unwarranted. While expressing his gratification that the last Congress saw fit to enlarge materially the active functions of the Public Health Service, he earnestly urges, in view of the immense field of operation it covers, its own independent work, and the material help it contributes to municipal health boards—to which we would add the aid furnished to investigators by its splendid publications—that Congress continue its good work by an immediate and adequate financial provision for the enlarged service. No one who has followed, as we have, the wonderful development of the Public Health Service and gauged its value to the country as a whole, can but approve the attitude of Secretary McVeagh, and with him express the hope that there shall be no further delay in providing the relatively small appropriations necessary to enable the service to carry out the improvements decided upon.

The belief of some people that economy and greater efficiency would be secured by consolidating the Public Health Service with certain other bureaus is shown, and rightly too, to be fallacious. Such a service requires individuality if a vigorous life is to be insured; its head must assume the responsibilities of its own clearly defined functions, and concentrate his attention upon these alone if they are to be carried on with full efficiency. To associate it with other bureaus would simply serve to forfeit its independence and compromise its usefulness. It would not absorb, but be absorbed. Elements of weakness and decay would now be introduced in the midst of a wonderful development which nothing now obstructs.—Editorial "N. Y. Medical Journal," December 14, 1912.

**Meeting of Kings County Society.**—The four hundred and sixteenth meeting of the Homœopathic Medical Society of the County of

Kings was held at the Medical Library Building, Brooklyn, September 9th. Dr. Orlando S. Ritch presided in the absence of the president, Dr. Roy Upham, and the vice-president, Dr. John F. Rankin. The Bureau of Diseases of the Chest, Dr. M. Louise Turton, chairman, presented two papers. Dr. Mary E. Richards read a paper entitled: "A Case of Dilation of the Heart." Dr. George H. Ding, read a paper entitled "A Case of Pneumonia Successfully Treated with Antimonium Tartaricum." These papers were discussed by Dr. Walter S. Rink, Dr. T. C. Wiggins, and Dr. Augustus Von der Luhe. Dr. Wiggins spoke of the method of treatment which is being studied by Dr. Abrams, of Chicago, known by the name of Spondylotherapy. The method being a percussion of the spinal processes of the vertebra, the percussion being made by a small hard rubber hammer. Rapid percussion will contract the blood vessels, slow percussion will dilate them. Percussion over the seventh cervical vertebra will have that action upon the heart. The Bureau of Homœopathy and Materia Medica, Dr. H. D. Schenck, chairman, presented four short papers, one by Dr. W. H. Aten, "Chininum Sulph. in Auditory Vertigo," and three by Dr. W. H. Freeman, "Lac Caninum in Follicular Tonsillitis," "Natrium Sulph. in Chronic Naso-pharyngeal Catarrh," and "Natrium Sulph. in Chronic Catarrhal Colitis." These papers were discussed by Dr. Alton G. Warner, Dr. A. Von der Luhe, Dr. Schenck, Dr. Aten, Dr. Ding, Dr. Edward Chapin, Dr. J. W. Fox, Dr. W. L. Love, Dr. R. L. Wood.

L. D. Broughton, Secretary.

**Chronic Catarrhal Diseases.**—Chronic catarrh never fails to indicate general constitutional debility. Local treatment is always desirable but for permanent results efforts must be directed toward promoting general functional activity throughout the body, and a general increase of systemic vitality. The notable capacity of Gray's Glycerine Tonic Comp. in this direction readily accounts for the gratifying results that can be accomplished through its use in the treatment of all chronic catarrhal affections, but especially those of the gastro-intestinal canal and respiratory tract. The particularly gratifying features in the results accomplished by Gray's Glycerine Tonic Comp. are their substantial and permanent character. This is naturally to be expected since they are brought about through restoring the physiologic balance of the whole organism.

**Ptosis.**—The modern conception of ptosis no longer regards it as involving any individual organ of the abdomen as a primary pathologic process, but that gastroptosis, enteroptosis, nephroptosis, and the like, are but end-results of a ptosis habit, having its root in the constitutional defects of the patient. Any device, therefore, which aims to correct or to prevent this condition must adapt itself to this broader conception of its character and *modus operandi*. It is because it has taken cognizance of these things and brought itself into alignment with them, that the Storm Binder has established for itself a unique and enviable reputation among abdominal binders. It conforms, in the most scientific way, to all that is most reliable and intelligent in our knowledge of the anatomy and physiology of ptosis; and while bringing the abdominal viscera into proper position, it does not interfere with the functional activity of either the viscera or the muscles, which is so essential to a natural recuperation of their normal power.—Clinical Medicine, August, 1913.



# THE HAHNEMANNIAN MONTHLY NEWS AND ADVERTISER

A Medical Newspaper

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NOVEMBER, 1913

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**Modern Medicine. Its Theory and Practice.** In original Contributions by American and Foreign Authors. Edited by Sir William Osler, Bart., M.D., F.R.S., Regius Professor of Medicine in Oxford University, England; Honorary Professor of Medicine in Johns Hopkins University, Baltimore; formerly Professor of Clinical Medicine in the University of Pennsylvania, Philadelphia, and in McGill University, Montreal; and Thomas McCrae, M.D., Professor of Medicine in the Jefferson Medical College, Philadelphia; Fellow of the Royal College of Physicians, London; formerly Associate Professor of Medicine in Johns Hopkins University, Baltimore. In five octavo volumes of about 1,000 pages each, illustrated. Volume I, Bacterial Diseases, Diseases of Doubtful or Unknown Etiology, Non-Bacterial Fungus Infections, the Mycoses. Just Ready. Price per volume, cloth, \$5.00 net; half morocco, \$7.00 net. Lea & Febiger, Publishers, Philadelphia and New York.

The first volume of the new "Osler's Modern Medicine" has just made its appearance. This new issue is published under the same editorial management as the original work, and the corps of distinguished contributors is virtually the same. The unusual excellence of the material presented is thereby assured, and the reduction in the price of the complete work, now in five volumes, will make it appeal strongly to all practitioners of medicine, and especially to those who do not possess the original work. Comparison with the first volume of the previous edition shows that the text has been set in much larger and clearer type, the size of the page has been increased, and there are nearly two hundred

pages more than in the original first volume. The many changes which have occurred in both the scientific and practical sides of medical knowledge in the last six years are shown in the complete reorganization of the subject matter. The introductory chapter, the historical section, the article on the biology of the Mosquito, the contribution on "Inheritance and Disease," the introductory section on Protozoa and the article on Life Insurance have been omitted. On the other hand, new or practically new sections will be found on Pellagra, Beriberi, Trypanosmiasis, Malta Fever, and on Electrical Diagnosis in Cardiac Diseases. The condensation has been principally in the etiological and pathological portions, and throughout the work increased stress has been laid on diagnosis and treatment.

**A Practical Treatise on Medical Diagnosis.** For Students and Physicians. By John H. Musser, M.D., LL.D., late Professor of Clinical Medicine in the University of Pennsylvania; formerly President of the American Medical Association, etc. New (sixth) edition, revised by John H. Musser, Jr., B.S., M.D., Instructor in Medicine in the University of Pennsylvania; Assistant Physician to the Philadelphia Hospital; Physician to the Medical Dispensary of the Presbyterian Hospital; Physician to the Medical Dispensary of the Hospital of the University of Pennsylvania. Octavo, 793 pages, with 196 engravings and 27 colored plates. Cloth, \$5.00 net. Lea & Febiger, Publishers, Philadelphia and New York, 1913.

The problem of diagnosis is the first one which confronts the physician every time he sees a patient, and upon it must depend the entire management and treatment of the case. For this reason the skilled diagnostician has a tremendous advantage over those who are less qualified, and his results are proportionately more successful. Every doctor therefore owes it to his patients, and more especially to himself, to establish in each case an unerring diagnosis. In no branch of medical science have the recent advances been more helpful; and in no other have they given us more exact methods. The appearance of a new edition of "Musser's Medical Diagnosis," setting forth the entire subject in its latest development, is therefore timely. The splendid store of clinical material in the book has been carefully preserved and brought abreast of our knowledge of to-day. The enormous advances since the appearance of the previous edition have resulted virtually in the rewriting of the entire volume, and this has made it possible by judicious condensation to reduce the book to about 800 pages without sacrificing any of those features which contributed to the great popularity of the earlier editions. In the sections on the infectious diseases, the diseases of the cardio vascular system, the metabolic diseases, the diseases of the gastrointestinal and the urinary systems, much new material has been incorporated. The chapter on the infectious diseases has been divided into two parts, the first containing those diseases due to vegetable organisms, the second those due to animal parasites. New sections have been added to the discussion of the disturbances of the internal secretions. A new chapter has been added dealing with the various functional tests of organic efficiency that have proved of such value in diagnosis and prognosis. The sections on laboratory diagnosis have been extensively revised. In the section on physical diagnosis many changes have been made, particularly in the division dealing with cardiac disorders, and new illustrations have been added representing the various types of

# Fellows\_Syrupus Hypophosphitum

**Quadraginta per annos et a medicis et ab  
aegris orbis terrarum totius probatus**

**Compositio sui generis neque imitabilis**

***Reject* < Cheap and Inefficient Substitutes  
Preparations "Just as Good"**



arrhythmia. In its new issue "Musser's Medical Diagnosis" stands unrivaled. Its high authority is evident on every page, and it presents the most modern thought and methods throughout.

**Pathology, General and Special.** A manual for Students and Practitioners. By John Stenhouse, M.A., B.Sc. (Edin.) M.B. (Tor.), formerly demonstrator of Pathology, University of Toronto, Toronto, Canada. Second edition, revised and enlarged; including selected list of State Board Examination Questions. 12mo. 278 pages, illustrated. Cloth, \$1.00, net. Lea & Febiger, Publishers, Philadelphia and New York, 1913.

The medical student of to-day, from the time he enters college until he graduates, is confronted with a bewildering mass of scientific information, the main facts of which he is expected to assimilate in four years. Even after he enters professional life he must still continue his studies in order to keep himself abreast with modern progress. To be able to grasp intelligently the new advances as they come and make practical application of them, he should have the fundamentals of the subject clearly and prominently in mind. To this end the *Epitome* is admirably suited; it is not a means of escape from wider or deeper reading, but an incentive and trustworthy guide to it. Stenhouse's *Epitome of Pathology* is unusual in the excellence of its text, illustrations and arrangement, and the questions at the end of each chapter will be found a strong mental stimulus, for they bring out in bold relief the important points throughout the volume.

**Labyrinth Papers.**—By Dr. George W. MacKenzie, Philadelphia, Pa. 222 pages. Published by Achey & Gorrecht, Lancaster, Pa. Price, \$2.00.

This book is of the utmost value to the neurologist and internist as well as the otologist. Published as a monograph, it is a collection of fifteen papers presented at various times in the last five years and covers the entire field of labyrinth disease, differential diagnosis, suppuration and treatment. Four chapters are devoted to nystagmus and its determination. The clearness of description and the masterly presentation of the subject, are what we expect from the author.

**A Manual of Surgical Treatment.**—By Sir W. Watson Cheyne, Bart., C.B., D.Sc., LL.D., F.R.C.S., F.R.S., Hon. Surgeon in Ordinary to H. M. the King; Senior Surgeon to King's College Hospital, and F. F. Burchard, M.S., (Lond.), F.R.C.S., Surgeon to King's College Hospital, and Senior Surgeon to The Children's Hospital, Paddington Green, London. New (2nd) edition. Thoroughly revised and largely rewritten. In five octavo volumes, containing about 3,000 pages, with about 900 engravings. Price, cloth, \$6.00, net, per volume. Lea & Febiger, Publishers, Philadelphia and New York, 1913.

The appearance of this volume completes the most recent and practical work on the market on *Surgical Treatment*. It is a work which should appeal strongly to the entire profession, for in each case it gives even minute details and describes the whole proceeding in clear language and with excellent illustrations. This volume treats of the surgical affections of the Pancreas, Liver and Spleen, the surgical affections of

the Neck, Larynx, Breast and Thorax and Genito-urinary Organs, including the Kidneys.

The unusual promptness with which the successive volumes have followed each other makes it possible for the doctor to secure a comprehensive work on Surgical Treatment, evenly up-to-date throughout—a very important consideration. This fifth volume, which completes the set, will be found fully as attractive as its predecessors.

**Progressive Medicine.**—A Quarterly Digest of Advances, Discoveries and Improvements in the Medical and Surgical Sciences. Edited by Hobart Amory Hare, M.D., Professor of Therapeutics and Diagnosis in the Jefferson Medical College of Philadelphia, etc., etc. Assisted by Leighton F. Appleman, M.D., Instructor in Therapeutics, Jefferson Medical College, Phila, etc., etc. Vol. III. September, 1913. "Diseases of the Thorax and its Viscera," including the heart, lungs and blood-vessels, "Dermatology and Syphilis," "Obstetrics," "Diseases of the Nervous System." Lea & Febiger, Philadelphia and New York.

This issue of "Progressive Medicine" is devoted to a consideration of "Diseases of the Heart, Lungs, Blood-vessels," "Dermatology" and "Syphilis," "Obstetrics" and "Diseases of the Nervous System."

The literature of each subject as it appeared during the past year has been critically gone over by various experts and the facts that, in their opinion are of most value, have been boiled down and presented to the profession.

Ewart's review of the treatment of tuberculosis by artificial pneumothorax is of especial interest and importance at this time.

**Collargolum Continues to be the Preferred Injection Medium in Skiagraphy and Uretero-Pyelography.**—While by far the greatest majority of American and European radiologists agree that Collargolum, which was first recommended by Voelcker and Von Lichtenberg in 1906 as the most advantageous injection medium into the bladder and renal pelvis, has not been equalled technically by any other material since suggested for this purpose, occasional reports of alleged injury from its use have recently appeared in the literature.

Dr. W. F. Braasch, of the Mayo Clinic, has found that severe reaction following pyelography, is usually the result of errors in technique or lack of care in the selection of the cases. In regard to the latter, careful perusal of Dr. Braasch's article is strongly recommended to all those interested, a short abstract being inadequate to do justice to this part of his report.

The following technical precautions are urged by him:

The Collargolum crystals should be carefully ground in a mortar when put into solution (10 per cent) and the latter filtered, otherwise undissolved crystals may be deposited on the walls of the pelvis and ureter and act as an irritant. The solution should be carefully warmed before injecting, not boiled, since it coagulates with boiling. The solution should be injected by the gravity method watching the patient for the slightest evidence of pain. From two to eight cc. will usually suffice unless symptoms of obstruction have been previously noted. A large ureteral catheter should be used so that the injected solution may drain away easily. The apparatus for the X-Ray and the injection should be so arranged that there will be no delay after the catheter is inserted.

**Personals.**—Dr. E. G. Whinna, of Philadelphia, the physician in charge of the Philadelphia Home for Infants, has just completed twenty years of continuous service, during which time he has cared for 2,160 children, out of which there were but eighty-four deaths, a mortality rate of three and two-fifths per cent, which speaks well for the Doctor and Homœopathy. In appreciation of the Doctor's service to the Home the managers sent the Doctor the following resolutions: Appreciating as we do your services as physician in charge at the Philadelphia Home for Infants, and realizing that the good health of our babies is in a large majority, due to the watchfulness and skill in handling their ailments, the managers wish to put on record these expressions of their gracious appreciation of your work during the past twenty years, and trust that you will long be spared to administer unto their ever changing family of little ones gathered at the Home.

Mary Bunting Wolf, Corresponding Secy.

The Class of Nineteen-Hundred-Thirteen of the J. Lewis Crozer Hospital Training School, held its Commencement Exercises on Wednesday afternoon, October, Twenty-ninth, at 3.30 P. M., in the reception hall of the J. Lewis Crozer Home for Incurables, Upland, Pa.

Miss Kornelia Theodosia Andrews announces the marriage of her niece Miss Gretchen Fiske Longley, to Doctor Raymond Sylvester Leopold, on Wednesday, the twenty-second of October, One thousand nine hundred and thirteen, at Hudson, New York.

**Offices for Rent.**—Splendid opportunity to sublet, suite of doctor's offices, handsomely furnished in best section of Philadelphia, 2035 Chestnut Street. Unexcelled door and phone service. \$25.00 monthly in advance for one physician; \$40.00 for two.

Telephone, 2261 Germantown, for appointment to inspect offices. Address, care of "Hahnemannian Monthly," 1807 Chestnut Street, Philadelphia, Pa.

**King's County Society Meets.**—The 469th regular meeting of the Homœopathic Medical Society of the County of Kings was held October 21st, the president, Dr. Roy Upham in the chair.

It was suggested that a change of meeting might be made on account of the conflict in dates with the two meetings of the New York State Society in February and October, which necessitates deferring the regular meeting from the second to the third Tuesday. Dr. Ritch moved that a change be made in the by-laws deferring the meeting night in future to the fourth Tuesday, which was laid over under the rules.

Dr. H. D. Schenck, chairman of the Legislative Committee, brought up the subject of the proposed amendment to the Health Laws, known as the National Narcotic Law, which was introduced in the House of Representatives at Washington, last June, by Congressman Harrison, of New York. It is described as H. R. 6282, and is pending at the present time in the Finance Committee of the Senate.

This bill regulates the manufacturing, selling, dealing in, dispensing, or distributing of narcotics. The provisions relating to physicians are very simple. Physicians must register and pay an annual tax of one dollar, and when purchasing narcotics make out a regular order form in duplicate, retaining a duplicate copy of such for two years. When the narcotics so ordered are received, the date of such receipt must be



# *Dr. Deimel Underwear* (LINEN-MESH)

The Dr. Deimel Underwear is the evolution of years of investigation and it claims the consideration of all who value health and comfort.

Its adoption proves a revelation of comfort to all who have hitherto endured the stuffy irritation of wool, or the clammy discomfort of cotton or silk.

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J. ELLWOOD LEE CO., Conshohocken, Pa.**

## *American Institute of Homoeopathy*

***Will Meet at Atlantic City in June, 1914***

**T**HE sessions of the Institute will not be held upon a pier, as was the case in 1906. One of the great hotels will accommodate us, and all meetings will be held under one roof.

June, 1914, should see the greatest attendance of members in the history of the Institute. Now is the time for homœopathic physicians not members of the Institute to send in their applications for membership so as to have the full benefit at this meeting. Write to the Secretary, 659 Rose Building, Cleveland, Ohio.

recorded in respect to each order. The dispensing or distribution of narcotics to patients by physicians, dentists, or veterinary surgeons registered under this act, in the course of their professional practice, and while personally attending such patient is entirely exempted from any restriction whatsoever. The object of the bill is to trace the purchase of narcotics and indicate illicit traffic.

The Federal Government has for some time urged the enactment of a narcotic law and that a bill might be framed which treats justly all the interests involved, a National Drug Conference was called, made up of representatives of each branch of the drug trade and of the medical profession, and the present bill is the result. The National Retail Druggists' Association gave the bill its unqualified endorsement. At the meeting of that Association in October, 1913, this action was repudiated and they are now opposing the bill.

Dr. Schenck read the following resolutions which were passed by the National Retail Druggists' Association in October:

Resolved: That the N. A. D. R. recommend and assist in the enactment of such legislation in the various States as will confine the practice of pharmacy to pharmacists and make the quality and kind of all medicines sold or dispensed, subject to the inspection and regulation of the same proper State authorities.

Resolved: That the legal department of the N. A. D. R. be instructed to prepare a model pharmacy bill for the guidance of State legislative committees.

Resolved: That we endorse the contention of President Merritt (President of N. A. D. R.) that physicians who choose to be their own pharmacists shall furnish their patients with prescriptions for all remedies applied just as they would if the prescriptions were to be dispensed by licensed pharmacists and that in case of the fatal termination where physicians have dispensed their own medicines, the local health officer and not the dispensing physician shall certify the cause of death and that this question be referred to the executive committee with power to act.

Dr. Orlando S. Ritch stated that the Legislature of the State of Maine has passed a law on the lines recommended by the resolution of the N. A. D. R. and that the physicians in that State are now in a quandry as the coroner must be called to certify the cause of death where physicians have prescribed and administered their own medicines.

Dr. Schenck then offered the following preamble and resolutions:

Whereas: House Bill No. 6282, introduced by Representative Harrison, last June, was designed to control the sale and distribution of narcotics, therefore be it

Resolved: That the Homœopathic Medical Society of the County of Kings at its 469th Session, heartily approves this bill now before the Finance Committee of the Senate and urges its passage. This Society condemns as class legislation and dangerous and against public convenience and welfare the amendments proposed by the National Association of Retail Druggists and prays that such amendments be left out of said bill.

Resolved: That a copy of these resolutions be sent to the Chairman of the Finance Committee of the Senate and to the Senators from this State.

These resolutions were adopted.

Dr. Schenck also brought up the subject of the standing that Homœo-

pathic surgeons would have in the proposed College of Surgeons of this country which is now being formed patterned after the College of Surgeons of England, with the power to give the degree of "Fellow of the American College of Surgeons." At the meeting of the American Institute a committee was appointed and a resolution was passed with the object of securing for Homœopathic surgeons the same rights as those of the allopathic school. At the recent meeting of the New York State Homœopathic Society the matter was brought up but was tabled without action.

Dr. Ritch moved: As the resolution of the American Institute states distinctly that the committee shall direct its efforts to securing for the surgical society the same recognition as other surgeons receive, this Society endorses the action of the American Institute. This motion was seconded and carried.

Dr. Ivimey Dowling, of Albany, read a paper entitled: "Surgery of the Accessory Nasal Sinuses for the relief of Occular Diseases." This paper was discussed by Drs. Warner and Schenck.

Dr. George F. Laidlaw, Professor of Theory and Practice of Medicine, New York Homœopathic Medical College, read a series of case histories from his hospital and private records under the title of "Diagnostic Problems."

L. D. Broughton, M.D., Secy.

#### PENNSYLVANIA STATE NOTES.

The Philadelphia Society for Clinical Research held its regular monthly meeting on Thursday evening, October 23rd, at 9 P. M., at the office of Doctor M. Sloan, 4825 Baltimore Avenue. A paper on "Colds" was well presented after which a hearty discussion took place. The meeting was well attended and a very enjoyable time was had by those present.

Percy A. Tindall, M.D., Secy.

The Clinico-Pathological Society of Philadelphia held its regular monthly meeting at Hahnemann College, Saturday evening, October 18, 1913, at 8.30 o'clock. The scientific program consisted of the following: "Regeneration of Bone in Surgical Diseases," Dr. D. Roman; "Interstitial Keratitis of Traumatic Organs," Dr. F. O. Nagle.

The Censors reported favorably the names of Dr. W. Hayes Brown, 6607 Lansdowne Avenue and Dr. H. F. Hinkle, 107 E. Lehigh Avenue. Many important topics were discussed by a large number of members present.

Benj. K. Fletcher, M.D., Secy.

The Germantown Homœopathic Medical Society held its regular monthly meeting at the "Majestic," Broad and Girard Avenue, on Monday, the Twentieth of October, 1913, at 9 P. M. A paper for discussion entitled "Achyilia Gastrica" was presented by Doctor T. B. Bradley, and which proved to be a very interesting feature of the occasion. The Censors reported favorably the name of Dr. Gordon Maxwell Christine. There was a full attendance of members and great interest was shown at this meeting.

Landreth W. Thompson, M.D., Secy.

The Physicians' Motor Club of Philadelphia held its annual Fall Smoker, on Tuesday evening, October 21st, at 9 P. M., at the Hotel



Walton, Broad and Locust Streets. The members were royally entertained, and a very enjoyable time was had by those present.

Howard A. Sutton, Secy.

**The Homœopathic Medical Society of the County of Philadelphia** held its regular monthly meeting at Hahnemann College, Thursday evening, October 9, 1913, at 8.30 P. M. A paper on "Auricular Fibrillation, its Diagnosis, Significance and Treatment," with demonstrations by polygraph and reflectoscope was presented by Dr. Wm. Rendell Williams, and was thoroughly enjoyed by all members present. The scientific session was followed by a social hour in which the members had a very enjoyable time.

Wm. M. Sylvis, M.D., Secy.

**The Homœopathic Medical Society of the 23rd Ward of Philadelphia** held its regular monthly meeting at "Three Tuns," where the members were the guests of Dr. F. C. Emery. A very interesting paper was read on "Goitre," after which many important business matters were taken up. The election of officers then took place. The meeting was well attended, and a thoroughly enjoyable time was had by those present.

John D. Boileau, M.D., Secy.

**The Women's Homœopathic Medical Association of Pittsburgh, Pa.,** held its regular monthly meeting at the office of Dr. Ella Walker, 17 Vine Street, Sharon, Pa., on Thursday, November 13, 1913, at 8 P. M. A paper on "Diseases of Children During Dentition" was read by Dr. Millie J. Chapman. Keen interest was shown at this meeting by a large number of members present.

Lydia B. Pierce, M.D., Secy.

**The Homœopathic Medical Society of Chester, Delaware and Montgomery Counties** held its bi-monthly meeting at the Turk's Head Hotel, West Chester, Pa., on October 14, 1913. The meeting was called to order by the vice-president, Dr. Morris Hughes, of Kennett Square, and Dr. Isaac Crowther, of Chester, performed the duty of secretary. The election of officers to serve the ensuing year resulted in the naming of the following: President, Dr. Morris Hughes; vice-president, Dr. J. Oscar Dicks, of West Chester; secretary and treasurer, Dr. Isaac Crowther; censor, Dr. Wm. Carner, of Pottstown. A paper on "Auricular Fibrillation, Its Diagnosis and Treatment," was read by Dr. W. R. Williams, of Philadelphia, after which a hearty discussion was entered into by a number of able doctors who were present at this meeting.

Preceding the afternoon session the doctors took dinner together at the meeting place. Among those present were: Dr. Charles R. Palmer, Dr. J. Oscar Dicks, and Dr. S. LeRoy Barber, of West Chester; Dr. Wm. Rendall Williams, Dr. Van Arsdalen and Dr. W. Mercer, of Philadelphia; Dr. F. H. Pounds and Dr. Isaac Crowther, of Chester; Dr. Trimble Pratt, of Media; Dr. H. Thomas Stockton, of Marcus Hook; Dr. Morris Hughes and Dr. R. W. Gregg, of Kennett Square, and Dr. Howard Terry, of Phoenixville.

**The Board of Managers of the Chester County Homœopathic Hospital** held its regular monthly meeting on October 14, 1913. Very encouraging reports were presented by all committees, and the work of the institution is progressing very satisfactorily.

The Nurses' Training School Committee reported that the five pro-

bationers, who entered the hospital at the opening of the institution the latter part of July, had been accepted by the Training School, having qualified after examination by the committee and the superintendent, Miss Mary C. Davies.

A washing machine and mangle operated by electric power have been installed in the laundry, meeting a much felt need.

The excellent work of the superintendent, Miss Davis, was especially commended by the Board of Managers.

**The Nurses' Commencement at Hahnemann.**—Twenty young women graduated from Hahnemann Training School for Nurses this year.

The exercises were held in the lecture hall of the college, and it was filled to overflowing with the friends of the nurses.

The exercises were opened with prayer by the Rev. W. T. Capers, of the Church of the Holy Apostles, who later made a sympathetic and inspiring address.

Mr. Charles D. Barney awarded the diplomas and Miss Hood presented the class pins. The list of graduates for the year is as follows:

Sarah E. Lemmon, Honeybrook, Pa.; Annie M. Richmond, Terre Hill, Pa.; Nora E. Smethers, Berwick, Pa.; Louise Schaller, Philadelphia, Pa.; Sarah Somerville, West Grove, Pa.; Marguerite Rupp, Philadelphia, Pa.; Elizabeth K. Weiler, Austria; Myrtle Bahner, Germantown, Pa.; Clara L. Davis, Syracuse, N. Y.; Edna M. Davis, Langhorne, Pa.; Harriet M. Herr, Lancaster, Pa.; J. Anna Doughty, Leeds Point, N. J.; Susan Confer, Philadelphia, Pa.; Anna Baker, Philadelphia, Pa.; Mabel Brightbill, Annville, Pa.; Mabel Hackman, Reading, Pa.; Edna Raudenbush, Ashland, Pa.; Bertha Brouard, England; Elizabeth Byrne, Berwyn, Pa.; Eula M. Lingle, Middletown, Pa.

**The Eye, Ear, Nose and Throat Association of Philadelphia** held its regular meeting at the Hahnemann Medical College, on Monday evening at 7 P. M.

The president, Dr. I. G. Shallcross, made the presidential address after which a number of clinical cases were presented by Drs. Speakman and Clay.

Jos. B. Clay, M.D., Secy.

**Warning Against a Prescription Fraud.**—The Department of Agriculture, under the Food and Drugs Act has recently been investigating a new trick of certain patent medicine and proprietary medicine vendors which it is believed, is deceiving a large number of people into spending money for patent medicines under the impression that they are getting regular physicians' prescriptions for nothing.

In a number of publications the Department finds advertisements are appearing which state that the man or woman whose name is attached was saved from death from one of a number of serious diseases through some wonderful prescription given to him or her by a regular physician of unusual skill who will not allow his name to be used because of medical ethics. The advertisement states that the writer feels it to be a duty to communicate this invaluable recipe to humanity in order to save them from similar ills. The offer is then made to supply this prescription without charge to any one who will address a post card to the advertiser. People who do not stop to wonder who is to pay for the advertisement and the return postage and writing of the prescription are caught by this fraud and ask for the prescription. In due course, a regular prescription is returned. This contains a number of

ordinary ingredients and then under a technical name will call for a large proportion of some patent medicine or proprietary drug. The recipient takes this to a drug store to be filled and the druggist finds that he has to buy some of this patent preparation in order to fill it. He, therefore, has to order a large package or bottle of it and to make a profit must charge the customer a good, stiff price for filling the prescription. The customer, of course, gets what is in effect simply a patent medicine, which, save that it bears a druggist's label and a prescription number, is the same as a patent medicine sold under the maker's own label and in the maker's own bottle.

The Government can not reach these people under either the Food and Drugs Act or the Postal Laws, because the scheme is so planned as to evade Government laws. The deception and misrepresentation appears in advertisements, circulars, letters, etc., separate from the package and the medicines are seldom sent through the mails. The best the Department can do, therefore, is to warn the people to be particularly suspicious of those who spend money for advertising space, postage, and letter writing, seemingly out of their love for humanity. In all of these cases there is a profit-making scheme back of the seeming philanthropy.

**Clinical Results with the Phylacogens.**—Under the above caption, Dr. R. W. Locher, Grafton, W. Va., in the "Memphis Medical Monthly," has this to say: "In judging the therapeutic value of a new preparation, it is advisable that a great number of case reports be considered; and in order that the medical profession may have a great number of cases from which to judge, it is the duty of every physician to report such results as he may have. The Phylacogens are of comparatively recent origin, and yet even at this early date they have displayed their ability to produce satisfactory and in some cases remarkable results in the treatment of a great variety of pathological conditions. \* \* \*

"We are informed that the Phylacogens are not claimed to be a 'cure-all' in any sense of the word, but simply valuable therapeutic agents in the treatment of numerous infectious conditions. From the very fact that all but Mixed Infection Phylacogens are to be directed against specific infections, it is necessary, before employing them, to make an accurate etiological diagnosis. For obvious reasons one cannot expect to produce results if Rheumatism Phylacogen is administered in a case that is really one of gonorrheal arthritis. Neither will an osteomyelitis or a syphilitic periostitis yield to Rheumatism Phylacogen, but the former may be logically treated with Mixed Infection Phylacogen. It would seem that this latter Phylacogen will ultimately prove of great value to the surgeon in combating post-operative infections, as well as infections following injuries of all kinds."

The writer then details fourteen case reports, covering a variety of diseases, and adds this by way of comment:

"From the foregoing cases it would be possible to draw numerous conclusions. What is especially striking, however, is that the Phylacogen treatment is apparently successful in the vast majority of cases and seems to give prompter and more definite results than is possible to secure with the usual recognized treatments. As a physician's experience increases, he finds a greater number of cases in which each of the Phylacogens may be used, with the expectation of great benefit resulting therefrom. In any event, it must be conceded that Phylacogen in its various forms presents great possibilities and must be classed as a therapeutic agent which is more than worthy of trial."



# THE HAHNEMANNIAN MONTHLY NEWS AND ADVERTISER

A Medical Newspaper

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**A Reference Handbook of the Medical Sciences.**—Embracing the entire range of Scientific and Practical Medicine and Allied Science. By various writers. Third Edition, Completely Revised and Re-written. Edited by Thomas Lathrop Stedman, A.M., M.D. Complete in eight imperial quarto volumes, Volume II. Wm. Wood & Co., New York.

In the second volume of this classical work the high standard of the previous volume has been maintained. We are impressed not only with the completeness of the text but also with its thoroughly up-to-date character. For example, under the heading of "Cardiography," we find the most complete description of all of the modern instruments for the investigation of the heart including the Mackenzie polygraph, the electro cardiograph, etc. The physician who adds this work to his library can do so with the assurance that he has at his disposal the most comprehensive and modern compilation of medicine and of the medical sciences now obtainable in any single publication.

**The Practitioner's Visiting List for 1914.** An invaluable pocket-sized book containing memoranda and data important for every physician, and ruled blanks for recording every detail of practice. The Weekly, Monthly and 30-Patient Perpetual contain 32 pages of data and 160 pages of classified blanks. The 60-Patient Perpetual consists of 256 pages of blanks alone. Each in one wallet-shaped book, bound in flexible leather, with flap and pocket, pencil with rubber, and calendar for two years. Price by mail, postpaid, to any address, \$1.20. Thumb-letter index, 25 cents extra. Descriptive circular showing the several styles sent on request. Lea & Febiger, Publishers, Philadelphia and New York.

Being in its thirtieth year of issue, "The Practitioner's Visiting List" embodies the results of long experience and study devoted to its development and perfection.

It is issued in four styles to meet the requirements of every practitioner: "Weekly," dated for 30 patients; "Monthly," undated for 120 patients per month; "Perpetual," undated, for 30 patients weekly per year, and "60 Patients," undated, for 60 patients weekly per year.

Printed on fine, tough paper suitable for either pen or pencil, and bound with the utmost strength in handsome grained leather, "The Practitioner's Visiting List" is sold at the lowest price compatible with perfection in every detail.

**The Elements of Bacteriological Technique.**—By J. W. H. Eyre, M.D., Director of the Bacteriological Department of Guy's Hospital, London. Second Edition, rewritten and enlarged. Octavo of 518 pages, with 219 illustrations. Philadelphia and London: W. B. Saunders Company, 1913. Cloth, \$3.00 net.

In this volume the author has endeavored to arrange briefly and concisely the various methods employed for the study of bacteriology. In the main, he has included only such procedures as are reliable and capable and give satisfactory results in the hands of persons of moderate experience. The book is profusely illustrated; the style of the text is clear and free from undue technicality. This work can be highly recommended as a practical and authoritative guide to the student or practitioner of medicine who desires to take up the study of this interesting subject.

**Oxford Medical Publications—Gout: Its Etiology, Pathology and Treatment.**—By James Lindsay, M.D. (Edin.) M.R.C.P. (Lond.) Hon. Physician, Formerly Hon. Pathologist and Res. Med. Officer, Royal Mineral Water Hospital, Bath. London, Henry Frowde, Oxford University Press; Hodder & Stoughton, Warwick Square, E.C., 35 West 32nd Street, New York City. Price, \$1.50.

Dr. Lindsay tells us in his preface that the object of this book is to present concisely to the profession the results of his observations in the study of six hundred cases. Certainly the results of such experience ought to contain much of interest and of value to all physicians who are called upon to treat this disease. We are pleased to note that the author has devoted quite a large proportion of his monograph to a consideration of the treatment of Gout. The book is a very practical and valuable contribution to the literature of Gout.

# Fellows\_Syrupus Hypophosphitum

**Quadraginta per annos et a medicis et ab  
aegris orbis terrarum totius probatus**

**Compositio sui generis neque imitabilis**

**Reject** < Cheap and Inefficient Substitutes  
Preparations "Just as Good"



**Private Duty Nursing.**—By Katharine DeWitt, R.N., Graduate of Mount Holyoke Seminary and of the Illinois Training School for Nurses; Assistant Editor of the "American Journal of Nursing." Philadelphia & London, J. B. Lippincott Company.

The aim of this book is to present to the young nurse certain guiding principles that will help her to solve the various problems met with in her daily work. No attempt has been made to present the subject in a technical way but the work is full of wholesome advice that will appeal to every young woman entering upon her duties as a nurse.

**Oxford Medical Publications: Skin Diseases in General Practice—Their Recognition and Treatment.**—By Haldin Davis, M.B., B.Ch., B.A. Oxon. F.R.C.S. Eng., M.R.C.P. Physician in Charge of the Skin Department, Paddington Green's Children's Hospital; Chief Assistant in the Skin Department, St. Bartholomew's Hospital, etc., etc. London, Henry Frowde, Oxford University Press, Hodder & Stoughton, Warwick Square, E.C., 35 W. 32d Street, N. Y. Price, \$3.75.

In the present volume the author has digressed from the ordinary arrangement of works of Dermatology and at the beginning of each chapter has given a list of the eruptions found on the particular portion of the body surface of which the chapter treats. No attempt is made to reach a diagnosis in a given case, the reader can turn to the chapter dealing with the lesions in the particular part of the body affected and, from his own knowledge and from the information given in the text, he will be able to select the one, the characteristics of which correspond most closely to the case in which he is interested. A minimum amount of pathology is included and the author has dealt especially with the more common diseases of the skin. The work contains a number of different colored plates and other illustrations.

**International Clinics.**—A Quarterly of Illustrated Clinical Lectures and especially prepared original articles on Treatment, Medicine, Surgery, Neurology, Paediatrics, Obstetrics, Gynecology, Orthopaedics, Pathology, Dermatology, Ophthalmology, Otology, Rhinology, Laryngology, Hygiene, and other topics of interest to students and practitioners.—By leading members of the medical profession throughout the world. Edited by Henry W. Cattell, A.M., M.D., Philadelphia, Pa., I.S.A. with the collaboration of John A. Witherspoon, M.D., Nashville, Tenn.; Sir William Osler, M.D., Oxford; A. McPhedran, M.D., Toronto; Frank Billings, M.D., Chicago; Chas. H. Mayo, M.D., Rochester; Thos. H. Rotch, M.D., Boston; John G. Clark, M.D., Philadelphia; James J. Walsh, M.D., New York; J. W. Ballantyne, M.D., Edinburgh; John Harold, M.D., London; Richard Kretz, M.D., Vienna. With regular correspondents in Montreal, London, Paris, Berlin, Vienna, Leipsic, Brussels and Carlsbad. Volume III. Twenty-third series, Philadelphia, London, J. B. Lippincott Company. Price, \$2.00.

This volume of the International Clinics is replete with articles of practical value and timely interest to all medical men. Boardman Reed contributes a valuable article on the "Diagnosis and Treatment of Gastric and Duodenal Ulcer"; Norman B. Gwynn a timely discussion on

"The Treatment of Pneumonia"; and an article by Abrams on the "Treatment of Disease of the Heart by Spinal Concussion," which contains much that will be new to the medical profession. Peter Daniel, of Charing Cross Hospital, London, and Dr. Edred M. Conrad, of London, have both contributed important articles dealing with Gastro Intestinal Toxemia. There are six important surgical papers and that by Thomas on "The Treatment of Acute Peritonitis" being one of general interest.

**The Medical and Sanitary Inspection of Schools.**—By S. W. Newmayer, A.B., M.D., in charge of the Division of Child Hygiene, Bureau of Health, Philadelphia. 12mo, 318 pages, with 71 engravings, and 14 full page plates. Cloth, \$2.50, net. Lea & Febiger, Publishers, Philadelphia and New York, 1913.

Public health work is no longer limited to the physician and the health officer, but is of great importance to every intelligent person. The sanitation of the school and the health of the pupils, with its wide-spread application, is acknowledged to be the most important phase of the public health problems of to-day. The volume by Dr. Newmayer is an authoritative work covering the subject in a clear, brief and practical manner. In this book the health officer can obtain detailed and concise information on efficient organization and administration of school inspection; the physician employed in or contemplating such work will find instructions in methods of diagnosis adapted to school examinations, which differ vastly from college teaching or private practice. The methods which bring the best results, both in the prevention of epidemics, and in the correction of physical defects, are given in detail. Civil service examination questions are appended for those desiring to prepare for competitive examinations.

The nurse and her relations to the work, to the physician, the teacher and the home are given in full. Chapters are devoted to inspections when physicians are not available.

For the teacher and other school authorities there have been included methods of co-operation and such valuable data as, how to teach the fundamental laws of health; definite and accurate information on the relation of mentality to physical conditions; new and common-sense views on the non-promoted, backward and mentally deficient child.

The sanitation of the school building and grounds is given full consideration, and a simple and very practical method of recording all information for the benefit of the child and the school is included. Instead of the citation of many examples, a complete system of records is presented. A large subject has been adequately covered in one small volume. The illustrations are not only numerous, but have been chosen to aid the reader.

**Manual of Venereal Diseases**—Oxford University Press.—Introduction by Sir Alfred Keogh, late director-general of the Army Medical Service; History, Statistics, Invaliding, etc. Brevet Colonel C. H. Melville, R.A.M.C., late Professor of Hygiene, Royal Army Medical College. Clinical Pathology and Bacteriology, Brevet Colonel Sir William Leishman, K.H.P., F.R.S., R.A.M.C., Professor of Pathology, Royal Army Medical College. Clinical course and treatment, Major C. E. Pollock, R.A.M.C. Second Edition, revised and largely rewritten with new matter by Major L. W. Harrison, R.A.M.C., Clinical Pathologist, Military Hospital, Rochester Row. London, Henry

Frowde, Oxford University Press,—Hodder and Stoughton, Warwick Square, E.C. 35 West 32nd Street, N. Y. Price, \$3.75 net.

This volume was originally prepared by the Advisory Board of the British Army for the guidance of the medical officers of the army in the management of venereal diseases. The work deals with methods of prevention, the pathology and diagnosis of venereal diseases, and takes up in detail those methods of treatment that have been found to give the best practical results. The work is abounding in practical information and as it now stands it represents a very authoritative and up-to-date presentation of the subject of venereal diseases.

**Meeting of Kings County Society.**—The 471st regular meeting of the Homœopathic Medical Society of the County of Kings was held December 9, 1913, Dr. Roy Upham, president, in the chair. Notice was given that at the annual meeting, amendments to the Constitution and By-Laws would be offered providing for associate members, and to change the meeting night to the fourth Tuesday. It is thought that men who are doing surgical work in special lines, who may not have the degree of M.D., dentists who are doing orthodontic operations, and those making a study of biological subjects, may be sufficiently interested in the Society meetings to attend, and to provide for them this plan of associate membership it is thought may be a broadening of the society's usefulness. Four names were presented for membership: William C. Braynard, M.D., William C. Powell, M.D., Glynn Young, M.D., and Herbert DuCret, M.D., all of Brooklyn.

Dr. Herbert D. Schenck, Consulting Ophthalmologist of the New York State Department of Health, read a paper entitled: "Physical Defects Discovered by an Examination of the School Children of New York State by the State Department of Health." This paper was illustrated by a series of lantern slides explained by Dr. B. F. Shea, D.D.S. Dr. H. M. Imboden, of New York, read a paper entitled: "The Roentgen Ray Method of Treatment of Fibroids." This paper was discussed by Dr. John F. Ranken, Dr. W. S. Rink, Dr. R. I. Lloyd, and Dr. W. W. Blackman. Dr. Addison S. Boyce, of New York, read a paper on "Some Interesting Cases of Extrauterine Pregnancy." This paper was discussed by Dr. Harriet Van Buren Peckham, Dr. Louise H. Turton, Dr. Ranken and Dr. E. Rodney Fiske.

Dr. Fiske, neurologist, presented a report on the death of Dr. William H. McLenathan. Dr. McLenathan was a Civil War veteran and was graduated from the New York Homœopathic Medical College in the Class of 1878. He settled in Brooklyn and became active in the Eastern District, establishing himself at 101 Division Avenue. He was a member of the State Society and joined the Homœopathic Medical Society of the County of Kings in July, 1878.

L. D. Broughton, Secy.

**The Clinico-Pathologic Society of Philadelphia** held its regular monthly meeting at Hahnemann College, Saturday evening, November 15, 1913, at 8.30 o'clock. The scientific program consisted of the following: "Stone in Bladder"—Presentation of an Unusual Case, W. C. Hunsicker, M.D. "Aortic Aneurism"—Presentation of a Case, C. D. Saul, M.D. "The Theory of the Aberhalden Test for Pregnancy"—N. S. Betts, M. D.

The Censors reported favorably the names of Dr. George J. Alexan-



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## The Hahnemannian Monthly

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OFFICIAL JOURNAL *of the*  
HOMOEOPATHIC STATE  
MEDICAL SOCIETY OF  
PENNSYLVANIA : : : :

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*Published at 1807 Chestnut Street : Philadelphia*

der, 1831 Chestnut Street, Philadelphia, and Dr. Howard Terry, Jr., Phoenixville, Pa.

The meeting was largely attended and great interest was shown by those present.

Benj. K. Fletcher, M.D., Secy.

**Personals.**—Dr. Charles H. Tait announces the removal of his office to 5302 Lancaster Avenue, Philadelphia, Pa.

**Wanted.**—Junior Internes in Flower Hospital, New York City, to serve until July 1, 1914, with privilege of application for Senior positions thereafter. Exceptional opportunities for surgical and medical experience. Graduates of homœopathic medical colleges preferred. Apply at once to R. F. Rabe, M.D., 616 Madison Avenue, New York City.

**Obituary.**—Dr. Zachariah Taylor Miller, who for many years was associated with Dr. James H. McClelland, on the staff of the Homœopathic Hospital, died at his home, 2015 Carson Street, Pittsburgh, Pa., on Friday morning, November 14th, at three A. M., and less than an hour later Dr. McClelland passed away at his home at Fifth and Wilkins Avenues. Dr. Miller's death was due to rheumatism of the heart. Dr. McClelland's death was the result of overwork and heart trouble. Both men were close friends and companions in their social and professional lives. Dr. Miller, like Dr. McClelland, was a distinguished practitioner of homœopathy in Pennsylvania. He studied medicine in New York Medical College and the Philadelphia Medical College. He held the highest offices in the County Society of Homœopathy, the State Society and the American Institute of Homœopathy, of which he was past president and an honored senior.

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#### PENNSYLVANIA STATE NOTES.

The Homœopathic Medical Society of the County of Philadelphia held its regular monthly meeting at Hahnemann College, Thursday evening, November 13, 1913, at 8.30 P. M. A paper entitled: "The Diagnosis of Empyema" was read by Doctor C. Sigmund Raue, the discussion of which was opened by Doctor William Steele. The report of the Committee on "The Medical Siftings" was read by Doctor John G. Wurtz, and proved to be of great interest. The scientific session was followed by a social hour at which time refreshments were served. Keen interest was shown at this meeting by a large number of members present.

Wm. M. Sylvis, M.D., Secy.

The joint committees on Hospital and Dispensary Abuse, of the County Medical Society and the Homœopathic County Medical Society held a meeting at Hahnemann College, Tuesday evening, December 16, 1913, at eight-thirty o'clock. Following are the speakers who took part in a symposium on the subject of "Hospital and Dispensary Abuse":—"The Scope of this Discussion and the Result Sought," Gordon M. Christine, M.D., Chairman Committee Homœopathic Medical Society. "Curbing Hospital and Dispensary Abuse," R. M. Little, D.D., Secretary of Society for Organizing Charity. "Need of Definite Information in Checking Hospital and Dispensary Abuse," Mr. Alexander Fleisher, Secretary,

Public Charities Association. "Methods of Controlling Hospital and Dispensary Abuse," Joseph B. Farrar, M.D., Chairman Committee County Medical Society. "Hospital Management," Mr. Richard Waterman, Financial Secretary Children's Hospital, Philadelphia. "Social Workers' Point of View," Miss Helen Glenn, Social Service Worker, University of Pennsylvania.

A general discussion limited to five minutes for each speaker then took place and proved to be of great interest. The members of the County Medical Society, who were the guests of the Homœopathic County Medical Society, were given a hearty welcome and the meeting was attended by a large number of members.

**The Germantown Homœopathic Medical Society** held its regular monthly meeting at the "Majestic," Broad and Girard Avenue, on Monday, November 17, 1913, at nine P. M. A paper on "The Treatment of Diabetes" was read by Dr. Clarence Bartlett and was well presented. The Censors reported favorably the name of Dr. Chauncy V. B. Vedder. The meeting was well attended, and a very enjoyable time was had by those present.

Landreth W. Thompson, M.D., Secy.

**The Philadelphia Society for Clinical Research** held its regular monthly meeting on Monday evening, November 24, 1913, at nine P. M., at the office of Dr. J. F. Rowland, 729 So. 60th Street. A paper on "Tuberculosis of the Eye," was very ably presented. The meeting was largely attended and a very enjoyable time was had by those present.

Warren C. Mercer, M.D., Secy.

**The Homœopathic Medical Society of the 23rd Ward of Philadelphia** held its regular monthly meeting at the office of Dr. J. V. Allen, Frankford, Pa. A paper on "Sulphur" was read after which a hearty discussion took place. The framing of new By-Laws was a very important feature of the meeting, and a large number of members were present.

John D. Boileau, M.D., Secy.

**The Homœopathic Medical Society of Delaware County** held its regular monthly meeting at the J. Lewis Crozer Homœopathic Hospital, in the staff-room, on Thursday, November 13, 1913 at 3.30 P. M. Dr. J. R. T. Gray, Jr., gave a very interesting talk and proved to be of great benefit. Keen interest was shown at this meeting by a large number of members present.

G. C. Webster, M.D., Secy.

**The Lehigh Valley Homœopathic Medical Society** met at The Hotel Karlton, Easton, Pa., on Thursday, December 4th, 1913. The following program was presented: "A Clinical Study of Empyema," C. Sigmund Raue, M.D., Philadelphia, Pa. "Concerning Co-operation of Homœopathic Medical Societies in Pennsylvania," Leon T. Ashcraft, A.M., M.D., Philadelphia, Pa. "Medical Jurisprudence," D. W. Straub, M.D., Bethlehem, Pa. "Massage, or Treatment of Diseases by Other Than Medical Means," J. P. Pursell, M.D., Sellersville, Pa.

S. C. Swartz, Secy.



**The Women's Homœopathic Medical Association of Pittsburgh, Pa.,** held its regular monthly meeting at the office of Dr. Ella D. Goff, 10 W. Moody Street, Pittsburgh, Pa., N. S., on Thursday, December 4, 1913, at eight P. M. A paper on "Pediatrics," covering Diseases of the Eyes, Ears and Nose, was read by Dr. Lydia B. Pierce, and was very ably presented. The meeting was a very interesting one, and was well attended.

Lydia B. Pierce, M.D., Secy.

**The Managers of the Hahnemann Association** held a meeting in the Chapel of the Hospital, on Tuesday, December 9, 1913, at 11.30 A. M. Miss Glenn, head worker in the Social Service Department of the University Hospital gave a very interesting talk, and was thoroughly enjoyed by all present.

**The Board of Managers of the Women's Southern Homœopathic Hospital** held its annual meeting on Thursday, November 13, 1913. At three P. M., J. M. Wilbur, D.D., gave a very pleasing address. This being donation Day the Hospital was well remembered by many friends of the Institution.

Anna M. Miller, Secy.

**The Eye, Ear, Nose and Throat Society of Philadelphia** held its regular meeting in Hahnemann College, Monday evening at seven P. M.

Dr. L. C. Wessels presented an obscure conjunctival case, Dr. Frank Nagle an incipient glaucoma, and Dr. Tindall a case of retinitis proliferans, and one presenting zonular cataract.

Joseph V. F. Clay, M.D., Secy.

**The Homœopathic Medical Society of New Castle County** held its regular meeting at Wilmington, Delaware, on December 12th. Dr. C. A. Ritchie presented a paper on "The Spine and How it Causes Disease."

**The South Philadelphia Medical Association** held its regular monthly meeting on Tuesday evening, November 18, 1913, at the residence of Dr. J. M. Hincken, with the President, Dr. Wm. M. Sylvis in the chair. The scientific feature was the address on backward children and demonstration of the Binat test for defectives by Dr. Hincken.

John W. McKenna, M.D., Secy.

**Horn and Brother Open London Branch.**—Owing to the international reputation attained by Horn's Standard Appliances, it has been found necessary to open a London branch at Colchester Chambers, 25 Worship Street, London, E. C. It is pleasing to note the extent to which American manufacturers of surgical appliances are being recognized abroad.

**The Society of Surgery, Gynecology and Obstetrics** held its regular meeting at Hahnemann College on Wednesday evening, November 26th. A paper on "Jejunostomy" was presented by Dr. Wm. B. Van Lennep. It was followed by a general discussion.

This society is a section of the Homœopathic Medical Society of the County of Philadelphia. All members of the above County Society, who are practicing any of these specialties, are eligible to membership. Meet-

ings are held in Hahnemann College at nine o'clock, the fourth Wednesdays of September, November, January, March and May. All are welcome to attend.

**Throat Affections.**—In all acute or chronic inflammations of the throat, pharyngitis, tonsilitis and laryngitis especially, Gray's Glycerine Tonic Comp. will be found of exceptional value. Used in appropriate dosage it allays congestion of the mucous membrane and underlying tissues, thus relieving pain and soreness, and by imparting tone to the local structures helps to restore normal conditions. "Gray's," moreover, is particularly useful as a prophylactic measure in those patients who are peculiarly subject to frequent colds. In such cases, its use from time to time tends to increase the resistance of the local mucous membrane and enable it to successfully combat germ attack. Public speakers and singers are also greatly benefitted by "Gray's" and if administered for several days before putting the throat or voice to unusual strain, it can be relied upon to increase the strength and vitality of the local structures.

**Reading Society Meets.**—A stated meeting of the Hahnemann Medical Society of Reading was held at the Homœopathic Hospital, Thursday evening, December 4, 1913.

The meeting was called to order by the vice-president, Dr. Wm. F. Marks, at 9.30 P. M.

Roll Call—Members Present—Dr. Marks, A. S. McDowell, C. R. Haman, S. L. Driebelbis, George Curry, Paul Gerhardt, W. A. Haman, Clifford D. Harvey, F. H. Lamman.

The applications for membership of Drs. George Krick, Ed. Golden and E. V. Lights, were reported on favorably by the Committee of Censors. The Society elected them as members.

Dr. S. L. Driebelbis, essayist for the evening, read a paper, title of which was "Difficulties of Labor," after which there was a general discussion of the subject. The Society adjourned.

Frank H. Lawrence, M.D., Secy.

**Department of Health.**—Rules and regulations concerning public drinking cups, towels, barbers' brushes, eating utensils and the reporting of additional contagious diseases.

**Public Drinking Cups, Towels, Barbers' Brushes and Eating Utensils.**

First: "Those responsible for establishing or conducting any public drinking place in the Commonwealth of Pennsylvania are hereby forbidden to furnish or permit others to furnish or keep any common drinking vessel for common use at any such drinking place provided this rule and regulation shall not preclude the use of vessels which are cleansed by washing in boiling water or are disinfected or destroyed after individual use. Public places within the meaning of this regulation shall include common carriers, private, public, parochial or Sunday Schools, industries, factories, theatres, shops, offices, hotels, etc., etc."

Second: "No person, persons or corporation within the Commonwealth of Pennsylvania shall furnish for public use any towel unless such towel be laundered or discarded after each individual use."

Third: "Barbers are hereby forbidden to use a common brush for

brushing the eyes of their patrons unless such brush be disinfected after each individual use."

Fourth: "Proprietors or persons in charge of public eating places are hereby forbidden to use drinking vessels, dishes, spoons, knives, forks, finger bowls and other eating utensils which have not been thoroughly cleansed after each individual use."

#### Reporting of Scabies and Impetigo-Contagiosa.

Fifth: "All physicians practicing within the limits of the State shall make an immediate report of each and every case of scabies and impetigo-contagiosa."

Samuel G. Dixon, Commissioner of Health.

**Reputable Manufacturing Pharmacists Do Not Furnish Emmenagogues for Immoral Purposes.**—Recently one of the leading manufacturing pharmaceutical houses received a letter upon the letter-head of a retail druggist, but signed by another name followed by the word "druggist." The person signing the letter may have been a clerk or successor of the druggist. The letter was as follows:

"There is practically no sale for your Emmenagogue Improved Pills, as few ladies know anything about them, and we can give no advice, as we know nothing about them ourselves as to dose, etc. Please let us know by return mail and tell us how to use, dose, etc."

Reply was made to the pharmacist whose name was on the letter-head, and was as follows:

"We have our doubts about Mr. ——— being a druggist, for we cannot imagine any druggist not knowing that it is not only immoral, but criminal, to sell an emmenagogue except upon a physician's prescription. We believe that every druggist who sells an emmenagogue direct to the consumer is put upon his notice that it will be used for an immoral and criminal purpose. Emmenagogues on our list are intended exclusively for the prescription trade and we never knowingly sell them for popular use or to be recommended and resold as remedies for female complaints, etc."

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**A Gift for Homœopathic Research.**—The announcement that Mr. Otto Beit, whose benefactions to medical science are already well known, has given £5,000 to the British Homœopathic Association to constitute a fund, the proceeds of which are to be devoted to research into problems of medicine, particularly those the solution of which is likely to throw light upon the range and mode of action of the homœopathic law, will not come as a surprise to those who know the true catholic spirit of the donor. It would be ungenerous, indeed, to cavil at such a magnificent donation towards medical research merely because this time the giver has not thought fit to bestow his favor upon the better known medical organizations, for the recollection of Mr. Beit's generosity towards the pursuit of medical investigation is fresh in the minds of all. Moreover, it must be admitted that the old-time prejudice against homœopathy, largely born of ignorance, is gradually breaking down in the light of modern discoveries, for, after all, the whole serum and vaccine treatment is but an adaptation, or rather an illustration, of the homœopathic law.—*The Medical Press and Circular* (London).













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